



4191-02U

SOCIAL SECURITY ADMINISTRATION

20 CFR Parts 404 and 416

[Docket No. SSA-2007-0101]

RIN 0960-AF69

Revised Medical Criteria for Evaluating Mental Disorders

AGENCY: Social Security Administration.

ACTION: Final rules.

SUMMARY: We are revising the criteria in the Listing of Impairments (listings) that we use to evaluate claims involving mental disorders in adults and children under titles II and XVI of the Social Security Act (Act). The revisions reflect our program experience, advances in medical knowledge, recommendations from a commissioned report, and public comments we received in response to a Notice of Proposed Rulemaking (NPRM).

DATES: These rules are effective January 17, 2017.

FOR FURTHER INFORMATION CONTACT: Cheryl A. Williams, Office of Medical Policy, Social Security Administration, 6401 Security Boulevard, Baltimore, Maryland 21235-6401, (410) 965-1020. For information on eligibility or filing for benefits, call our national toll-free number, 1-800-772-1213, or TTY 1-800-325-0778, or visit our Internet site, Social Security Online, at <http://www.socialsecurity.gov>.

SUPPLEMENTARY INFORMATION:

Background

We are revising and making final the rules for evaluating mental disorders we proposed in an NPRM published in the Federal Register on August 19, 2010 (75 FR 51336). Even though these rules will not go into effect until January 17, 2017 for clarity, we refer to them in this preamble as the “final” rules. We refer to the rules in effect prior to that time as the “prior” rules.

In the preamble to the NPRM, we discussed the revisions we proposed for the mental disorders body system. To the extent that we are adopting those revisions as we proposed them, we are not repeating that information here. Interested readers may refer to the preamble to the NPRM, available at <http://www.regulations.gov> under docket number SSA-2007-0101.

We are making several changes in these final rules from the NPRM based upon some of the public comments we received. We explain those changes in later sections of this preamble. We are also making minor editorial changes throughout these final rules. We are making final the non-substantive editorial changes, the conforming changes in other body systems, and the changes we proposed in 114.00.

Why are we revising the listings for evaluating mental disorders?

We developed these final rules as part of our ongoing review of the listings. We are revising the listings to update the medical criteria, provide more information on how we evaluate mental disorders, reflect our program experience, and address adjudicator questions. The revisions also reflect comments we received from medical experts and the public at an outreach policy conference, in response to an Advance Notice of Proposed Rulemaking (ANPRM) published on March 17, 2003 (68 FR 12639), and in response to the NPRM.

When will we begin to use these final rules?

As we noted in the dates section of this preamble, these final rules will be effective on January 17, 2017. We delayed the effective date of the rules to give us time to update our systems, provide training and guidance to all of our adjudicators, and revise our internal forms and notices before we implement the final rules. The prior rules will continue to apply until the effective date of these final rules. When the final rules become effective, we will apply them to new applications filed on or after the effective date of the rules, and to claims that are pending on or after the effective date.¹

Public Comments on the NPRM

In the NPRM, we provided the public with a 90-day comment period that ended

¹ This means that we will use these final rules on and after their effective date, in any case in which we make a determination or decision. We expect that Federal courts will review our final decisions using the rules that were in effect at the time we issued the decisions. If a court reverses our final decision and remands a case for further administrative proceedings after the effective date of these final rules, we will apply these final rules to the entire period at issue in the decision we make after the court's remand.

on November 17, 2010. We received 2,245 public comments during this comment period. The commenters included national medical organizations, advocacy groups, legal services organizations, national groups representing claimants' representatives, a national group representing disability examiners in the State agencies that make disability determinations for us, individual State agencies, and other members of the public. A number of the letters provided identical comments and recommendations.

We published a notice that reopened the NPRM comment period for 15 days on November 24, 2010 (75 FR 71632). We reopened the comment period to clarify and seek additional public comment about an aspect of the proposed definitions of the terms "marked" and "extreme" in sections 12.00 and 112.00 of our listings. We received 156 additional comments during the reopened comment period, for a total of 2,401 total public comments.

We considered all of the significant comments relevant to this rulemaking. We condensed and summarized the comments below. We have tried to present the commenters' concerns and suggestions accurately and completely, and we have responded to all significant issues that were within the scope of these rules. We provide our reasons for adopting or not adopting the recommendations in our responses below.

We also received comments supporting our proposed changes. We appreciate those comments; however, we did not include them. Finally, some of the comments were outside the scope of the rulemaking. In a few cases, we summarized and responded to

such comments because they raised public concerns that we thought were important to address in this preamble. For example, we received comments about the statutory policies regarding how we evaluate substance use disorders. We thought that it was important to explain how we follow the requirements of the statute for claims in which a substance use disorder is involved. However, in most cases, we did not summarize or respond to comments that were outside the scope of our rulemaking. As one example, several commenters asked us to give equal weight to evidence that we receive from all medical sources and to consider that evidence separately from the other information collected from non-medical sources. We will retain these types of comments and consider them if they are appropriate for other rulemaking actions.

General Comments

Comment: One commenter, a clinical psychologist, did not recommend eliminating the paragraph A criteria from the prior listings because the criteria provide a basis for comparing and assessing the severity of different disorders, such as dysthymic disorder compared with a major depressive disorder. The commenter also noted that “it may be premature to implement significant modification [to the] rules without having the benefit of the newest edition of the Diagnostic and Statistical Manual being available.”

Response: We agreed with the commenter and adopted the recommendations. The paragraph A criteria provide important medical information that we consider when we make disability determinations. The criteria also identify mental disorders that are

significant and that we should consider at the “listings step” of the sequential evaluation process. For these reasons, we retained the paragraph A criteria in each listing. We revised most of the paragraph A criteria using the diagnostic features for the corresponding categories of mental disorders in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition² (DSM-5).

Comment: A commenter suggested that we use the terms “health” or “healthcare” instead of “medical,” where appropriate.

Response: We adopted the comment and used the recommended terms where appropriate.

Comment: The spokesperson for an organization strongly recommended that SSA reviewers who possess child and adolescent health backgrounds review the applications of children to ensure the most accurate evaluation of the unique mental health considerations of the pediatric population.

Response: This comment is outside the scope of the NPRM, and we did not make any changes in these final rules in response to it. Section 221(h) of the Act requires us to make every reasonable effort to ensure that a qualified psychiatrist or psychologist has evaluated the case if the evidence indicates the existence of a mental impairment and we find that the person is not under a disability (see also §§ 404.1615(d) and 416.903(e)).

² American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Arlington, VA, American Psychiatric Association, 2013.

After we published the NPRM, Congress passed the Bipartisan Budget Act of 2015 (BBA), Pub. L. 114-74. 129 Stat. 584. For determinations made on or after November 2, 2016, section 832 of the BBA requires us to make reasonable efforts to ensure that a qualified physician (in cases involving a physical impairment) or a qualified psychiatrist or psychologist (in cases involving a mental impairment) has completed the medical review of the case and any applicable residual functional capacity assessment. We will address the requirements of section 832 of the BBA in a separate rulemaking.

Sections 404.1520a and 416.920a—Evaluation of Mental Impairments

Comment: Some commenters objected to the proposal to remove §§ 404.1520a and 416.920a. These regulations contain guidance about the “special technique” that we use to evaluate the severity of mental impairments for adults, known as the “psychiatric review technique.” One commenter stated that the technique is a decision-making tool that is useful for our medical consultants and adjudicators. Another commenter indicated that the psychiatric review technique increases consistency in case outcomes.

Response: We adopted the comments because we agree with the reasons that the commenters provided. The final rules keep the special technique described in §§ 404.1520a and 416.920a and make the conforming changes necessary to implement these rules.

Sections 12.00A and 112.00A—How are the listings for mental disorders arranged, and

what do they require?

Comment: After we published the NPRM, the American Psychiatric Association (APA) made the public aware that it was developing the DSM-5. Several commenters stated that it might be premature to implement significant modification to SSA's rules on mental disorders without the benefit of the DSM-5 being available. Some commenters recommended postponing these final rules until after the APA published the DSM-5 so these rules could include the updates in medical understanding reflected in the DSM-5.

Response: The APA published the DSM-5 in May 2013. We adopted the recommendation to include updates in medical knowledge in these final rules, where appropriate. For example, we:

- revised the titles of most of the listings to reflect the terminology that the DSM-5 uses to describe categories of mental disorders;

- added a new listing for trauma- and stressor-related disorders that is separate from the listing for anxiety disorders;

- consulted the descriptions of mental disorders in the DSM-5 when we described the mental disorders that we

evaluate under each listing; and

- consulted the diagnostic criteria in the DSM-5 when we revised the criteria for each listing.

Comment: A commenter recommended that we group listings 12.02, 12.05, and 12.11 under a heading separate from functional psychiatric disturbances because “intellectual disabilities and psychiatric disturbances are qualitatively different from each other and require different methods of determination.”

Response: Although we acknowledge the distinction made by the commenter, we did not adopt the comment. We decided to continue the prior structure of headings, which lists each category of mental disorder as a separate listing, similar to the separate chapters of mental disorders in the DSM-5. Although the listings for cognitive disorders and psychiatric impairments appear next to each other in the ordering of the listings, and occasionally alternate within the ordering of the listings, they have separate titles, separate identifying numbers, and separate medical criteria. This format provides a clear distinction among the types of mental disorders. Additionally, given the relatively small number of mental disorders listings, grouping listings 12.02, 12.05, and 12.11 under separate headings would complicate the listings at a time when we are trying to simplify them. We maintained the ordering and numbering of the listings from our prior rules to ease the transition to these final rules, when possible.

Comment: One commenter suggested that the listings should consider combined disability for schizophrenia (12.03) and cognitive disorder (12.02), and for mood disorder (12.04) and cognitive disorder, because co-morbidity between these disorders “is the rule rather than the exception. The listings should expect this, and allow for this.” Another commenter stated that it is important to “acknowledge the impact that dual diagnoses may have on an individual’s functioning.”

Response: We did not adopt the comment. Although we appreciate the issues raised by the commenters, it is not necessary or practical to provide listings that combine mental disorder categories for four reasons. First, §§ 404.1523 and 416.923 require us to consider the combined effect of all of a person’s impairments in our disability determination processes. Second, when we determine whether a person’s mental disorder is disabling under the law, it does not matter whether the person has a diagnosis or a combination of diagnoses. The controlling issue is whether the medically determinable mental impairment(s) result(s) in limitations in functioning that prevent the person from working. Third, given the numerous examples of co-morbid mental disorders, we do not think it is feasible to provide listings for all possible co-morbidities. Fourth, the listing criteria allow us to evaluate the range of effects of any combination of mental disorders on functioning independently, appropriately, effectively, and on a sustained basis.

Sections 12.00B and 112.00B—Which mental disorders do we evaluate under each listing category?

Comment: One commenter noted that the guidance to adjudicators in paragraph “c” of all the 12.00B sections says, “. . . examples of disorders in this category include . . . ,” without clarifying that the list of examples is not exhaustive. The commenter recommended that we make clear the non-exhaustive nature of the list of examples of mental disorders in each listing category by adding, “may include, but are not limited to.”

Response: We did not adopt the comment. Several sections of the introductory text have lists that are not exhaustive. It would make the listings more difficult to use if we included repeated statements of “may include, but are not limited to” in every place in the listings where there is a list. The words “examples” and “include” sufficiently indicate that the lists are not exhaustive.

Comment: One commenter noted that in proposed 12.00B1, which is the description of listing 12.02, we provided a cross-reference to the documentation and evaluation guidance in 11.00F for traumatic brain injury (TBI) only. The commenter recommended that the entire “Dementia category” be cross-referenced so that “adjudicators give full consideration to both the neurological and mental limitations” associated with all the disorders evaluated under listing 12.02.

Response: We adopted this suggestion and ended final 12.00B1b with a parenthetical statement explaining that we evaluate neurological disorders under that body system (see 11.00). We evaluate cognitive impairments that result from neurological disorders under 12.02 if they do not satisfy the requirements in 11.00.

Comment: One commenter was concerned that the description of listing 12.02 did not appear to include the effects of head injuries that do not rise to the level of TBI. For example, adults with mental disorders who are homeless or incarcerated may have histories of physical abuse including blows to the head, fights or falls involving episodes of unconsciousness, or as pedestrian victims of vehicular accidents. These brain injuries, which can result from recurring, less traumatic assaults rather than from one or more traumatic injuries, can nevertheless add up to impaired cognitive functioning. The commenter urged us to include some direction to adjudicators in the listing about how to evaluate such histories.

Response: We did not adopt the comments. We agree that it is important for adjudicators to understand the differing impacts of TBI and a history of concussive injuries, as well as the lasting effects of substance use on the brain. However, the list of symptoms and signs and the examples of disorders in this listing category are not limited to those presented in 12.00B1a. Furthermore, they would readily include a history of concussive injuries resulting in brain damage. We believe that the list of symptoms and signs is sufficiently descriptive of the brain damage a person may incur after several such injuries that it is not necessary to expand it at this time.

Comment: A few commenters stated that it is difficult to determine whether listing 12.02 would apply in circumstances when cognitive limitations have resulted from the impact of substance use. To address this, a commenter recommended “some

expansion of the symptoms or some addition to the overarching cognitive difficulties in this category.”

Response: We adopted this comment. We included substance-induced cognitive disorder associated with drugs of abuse, medications, or toxins among the examples of disorders in this category in 12.00B1b.

Comment: Some commenters stated that the descriptions in 112.00B of two listing categories, proposed listing 112.02 (dementia and amnestic and other cognitive disorders) and proposed listing 112.11 (other disorders usually first diagnosed in childhood or adolescence) were “incompletely specified.” The commenters noted that listing 112.02 includes TBI, but that there are many other types of childhood brain insult, including those related to tumors, epilepsy, cancer treatment, genetic disorders, exposure to toxins, and perinatal brain insults. The commenters observed that children with these conditions “fall more clearly in the first [listing] . . . than in the second. Unfortunately, which category encompasses these conditions is unclear from the descriptions of these two categories.”

Response: We partially adopted these recommendations. We included mental impairments resulting from vascular malformation or progressive brain tumor in final 112.00B1b, where we list examples of disorders that we evaluate under listing 112.02. We did not include all of the examples that the commenters recommended because the lists of example disorders in 112.00B are not exhaustive. The examples include the

impairments that we see most often in child claimants seeking benefits under our program. We may find that other disorders not included in the examples may meet or medically equal the respective listings, depending on the facts of each case.

We also added an explanation to final 112.00B1b that we evaluate neurological disorders under that body system (see 111.00). We evaluate cognitive impairments that result from neurological disorders under 112.02 if they do not satisfy the requirements in 111.00. We evaluate catastrophic genetic disorders under the listings in 110.00, 111.00, or 112.00, as appropriate. We evaluate genetic disorders that are not catastrophic under the affected body system(s).

In addition, to respond to this comment, we updated the title of listing 112.11 to “neurodevelopmental disorders,” which is the term used in the DSM-5 for these types of impairments, to better distinguish the applicability of listings 112.02 and 112.11.

Another intended distinction between these two listings is that of knowing, compared with not knowing, the cause of a child’s mental impairment. If we know that the mental impairment has an organic cause, we will evaluate the impairment under listing 112.02; if the cause is not known, we will evaluate the impairment under listing 112.11.

Comment: The spokesperson for a professional organization recommended that we add language to proposed 112.00B7, where we describe personality disorders in our childhood listings, to indicate that personality disorders “typically have an onset in adolescence or early adulthood.” The commenter stated that this characterization is

consistent with information in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision³ (DSM-IV-TR).

Response: We adopted the comment because the DSM-5 also indicates that personality disorders have an onset in adolescence or early adulthood. Final 112.00B7a includes the sentence, “Onset may occur in childhood but more typically occurs in adolescence or young adulthood.”

Comment: A commenter noted that intermittent explosive disorder is “a diagnosis for which there is remaining confusion . . . [but which is] the most serious form of unclassified disorders of impulse control.” The proposed guidelines for children are “very clear that problems of self-regulation and impulsivity may potentially be [the] bases for [a finding of] ‘marked’ [or extreme] functional limitation.” However, in the absence of other specific mental disorders, this disorder does not seem to fit a clear category, and adjudicators could overlook it in a disability determination. The commenter recommended that we state clearly that the diagnosis can apply to both children and adults.

Response: We adopted the comment. We are aware that the DSM-5 includes this diagnosis under the category of disruptive, impulse-control, and conduct disorders. In response to this comment, we added “intermittent explosive disorder” to the lists of example disorders that we evaluate in final 12.00B7b and 112.00B7b. We also revised

³ American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, D.C., American Psychiatric Association, 2000.

the titles and the criteria for listings 12.08 and 112.08 to include impulse-control disorders. The new paragraph B4 criterion for adults and for children age 3 to age 18, adapt or manage oneself, also provides for consideration of problems of self-regulation and impulse control.

Comment: One commenter had several suggestions about proposed 12.00B8. First, the commenter recommended that we wait until the expert panel that was revising the DSM-IV completed its work before we proposed a definition for autism spectrum disorder (ASD). The commenter raised concern that failing to consider a new DSM-5 definition of these disorders could foster confusion among professionals, parents, and consumers, and could breed inconsistent definitions of ASD that might hinder the rights of children and adults to secure important benefits. Second, the commenters recommended that we should conduct in-depth research, expert consultation, and study to ensure that any proposed revision in the definition of ASD is warranted and correct. Third, the commenter stated that our proposed definition and criteria did not recognize that the core nature of ASD is not an intellectual impairment but a social and behavioral disability. Therefore, the commenter thought that the use of the paragraph B1 criteria (understand, remember, or apply information) and B3 criteria (concentrate, persist, or maintain pace) pointed to our lack of understanding of ASD.

Response: We did not adopt the comments, although we appreciated them, particularly given the intense concern and dialogue currently focused on ASD among medical professionals, educators, and parents. The APA “defines” or characterizes

mental disorders based on research, consultation, and study in its diagnostic and statistical manual. The discussion of ASD in final 12.00B8a and 112.00B8a is not a “proposed definition”; it is the characterization of this disorder found in the DSM-IV-TR and DSM-5. We understand that ASD is a highly complex disorder that interferes with a person’s functioning in many ways, especially communication and social interaction. Therefore, the description of ASD in 12.00B8b begins with a discussion of social interaction and communication skills to reflect the emphasis in the DSM-5 on these two aspects of functioning.

Although some people with ASD do not have cognitive limitations, some do. Any method of evaluation intended to apply to everyone with ASD must provide criteria for assessing the range of possible limitations that individuals with the disorder may experience. For this reason, we apply all four of the paragraph B criteria, including paragraphs B1, understand, remember, or apply information, and B3, concentrate, persist, or maintain pace, to ASD.

Comment: A commenter recommended that if the APA removed “Asperger’s disorder” as a separate diagnosis in the DSM-5, then these final rules should be consistent with that change.

Response: We adopted the comment, and we removed the references to Asperger’s disorder in final 12.00B8b and 112.00B8b.

Comment: Some commenters suggested including specific mention of conduct disorder and oppositional defiant disorder in proposed 112.00B9c, where we listed examples of disorders we would evaluate under listing 112.11 (other disorders usually first diagnosed in childhood or adolescence). One of the commenters explained that these disorders are included in a similar chapter of the DSM-IV and are common diagnoses in childhood and adolescence.

Response: We did not adopt the comment. In the DSM-5, these disorders are now included in their own category of “disruptive, impulse-control, and conduct disorders.” To be consistent with the DSM-5, final listing 112.08, personality and impulse-control disorders, now includes aspects of “disruptive, impulse-control, and conduct disorders.” For example, final 112.00B7a includes impulsive anger and behavioral expression “grossly out of proportion to any external provocation or psychosocial stressors.” As another example, final 112.00B7b lists intermittent explosive disorder as one of examples of disorders we evaluate under listing 112.08. Additionally, the paragraph A criteria for final listing 112.08 includes “recurrent, impulsive, aggressive behavioral outbursts.”

We did not include conduct disorder or oppositional defiant disorder in the list of examples of disorders that we evaluate under listing 112.08 because, in our programmatic experience, these impairments do not typically result in marked limitation in two of the “paragraph B” criteria, or extreme limitation in one of the criteria. However, the list of examples in final 12.00B7b is not exclusive. Either or both of these impairments may

meet or medically equal the criteria in listing 112.08, depending on the facts of the individual case.

Sections 12.00C and 112.00C–What evidence do we need to evaluate your mental disorder? (Proposed 12.00G and 112.00G)

Comment: Several commenters requested that we include language in 12.00G2 that “requires adjudicators to consider the factors in the regulations for weighing medical opinions.”

Response: We partially adopted this comment. We typically do not repeat guidance that we provide elsewhere in our regulations. However, in response to this comment, we added a reference to our regulations on evaluating opinion evidence in 12.00C1 and 112.00C1.

Comment: We received various comments regarding our reference to health care providers, such as physician assistants, nurses, licensed clinical social workers, and therapists, as medical sources whose evidence we will consider when evaluating a person’s mental disorder and the resulting limitations in the person’s functioning. Some organizations and individual commenters strongly supported our inclusion of these professionals, because they may be most familiar with a person’s limitations in functioning. However, a professional medical organization opposed characterizing the reports of non-physician mental health professionals as “evidence from medical sources,”

unless the work of the practitioner is recognized as medical in scope. The spokesperson maintained that any reference to “medical sources” of information should be limited to medical professionals such as medical doctors (MDs) or doctors of osteopathy (DOs). Other professional organizations said that our reference to “physician” and “psychologist” should be more specific, and should include references to psychiatrists and clinical neuropsychiatrists.

Response: We did not adopt the recommendations. Our recognition of non-physician health care providers as other medical sources of evidence is not a new rule; see §§ 404.1513(d) and 416.913(d). The list of these other medical sources in our regulations is not all-inclusive, and our mention of licensed clinical social workers and clinical mental health counselors in final 12.00C2 is appropriate, given their roles in the treatment of people with mental disorders in both private and public settings. We believe that these other medical professionals—because they typically see patients regularly—are important sources of the evidence we need to assess the severity of a person’s mental disorder and the resulting limitations in the person’s functioning.

Comment: The spokesperson for an organization questioned why we “separated” therapists and licensed clinical social workers (LCSW) in proposed 12.00G2, because LCSWs are therapists. This person noted that because the scope of social work is so broad, some people may be confused about the specific expertise of LCSWs, which is the largest group of therapists in the country.

Response: We adopted this comment. We replaced the example of “therapists” with that of “clinical mental health counselors” in final 12.00C2 for accuracy and completeness.

Comment: The spokesperson for an organization requested that we add case managers and similar staff as examples of non-medical sources of evidence.

Response: We adopted the comment. We added the examples of community support and outreach workers and case managers in final 12.00C3 and 12.00C5b where we discuss evidence from third parties and non-medical sources of longitudinal evidence.

Comment: While commenting on proposed 12.00D and expressing concerns about standardized testing, one person said that because mental disorders are not amenable to testing and are different for every individual, we should evaluate each person on a case-by-case basis, using the best sources of information about the person’s condition. Some health care professionals, while acknowledging our need to make the determination of disability as “efficient” and “objective” as possible, urged us to recognize the importance of clinicians’ observations, interpretations, and evaluations of their patients’ mental disorders. Many direct service providers stressed the importance of obtaining information from people who, because they know and spend time with the person with a mental disorder, are in the best position to tell us how the person functions.

Response: We adopted the comments. We removed the provision in proposed

12.00D regarding standardized testing from these final rules. We discuss that change and our reasons for making it below, where we explain our responses to public comments about sections 12.00F and 112.00F.

Regarding the commenters' suggestions about sources of evidence and our evaluation of mental disorders, we appreciate the views and recommendations, and the NPRM and the final rules reflect them. For example, in final 12.00C2, we explain how we consider evidence from medical sources. We state that we consider all relevant medical evidence, including the results of physical or mental status examinations, structured clinical interviews, psychiatric or psychological rating scales, measures of adaptive functioning, and observations and descriptions of how a claimant functions during examinations or therapy. As another example, in final 12.00C3, we state that we consider evidence from third parties who can provide information about a claimant's mental disorder, including a claimant's symptoms, daily functioning, and medical treatment. We added to the list examples of people who can provide us with this evidence. The list of examples includes family, caregivers, friends, neighbors, clergy, social workers, shelter staff, or other community support and outreach workers.

Regarding the suggestion for a case-by-case assessment of each claimant, our longstanding principle has been to evaluate each person who files a disability claim on an individualized basis. We understand that no mental disorder affects all individuals in the same way; rather, mental disorders affect each person uniquely in every aspect of his or her life. Our process of evaluating four criteria that reflect a person's functional abilities

and rating the person's limitations for each criterion is just one example of our commitment to individualized, case-by-case assessments.

Comment: One commenter recommended that we recognize the unique circumstances of people who are experiencing homelessness, and permit longitudinal evidence of their mental disorders from social workers.

Response: We adopted this comment. In final 12.00C5b, we included "chronic homelessness" as an example of a situation that may make it difficult to provide longitudinal medical evidence. This section also lists social workers as a source of longitudinal evidence of a person's mental disorder.

Comment: Some commenters recommended that we emphasize the value and importance of using standardized assessment instruments specifically developed for use with children. The commenter suggested that, for example, additional language could be included in proposed 112.00G5 to ensure that tests used are appropriate to the age and condition of the child.

Response: Although we appreciate the concern raised by the commenter, we did not adopt the comment. We cannot control what standardized instruments medical and educational providers use when evaluating children. We consider all relevant evidence that we receive. If we receive the results from standardized assessment instruments not specifically developed for use with children, or that were not appropriate to the age and

condition of the child, those are important facts that we will consider when we evaluate the evidence.

To the extent that the comments pertained to our policies for ordering standardized assessment instruments when we purchase psychological consultative examinations for children, the comment would be outside of the scope of the proposed rulemaking. Our policies regarding consultative examinations for children are in §§ 416.917-416.919t.

Comment: Spokespersons for two professional organizations expressed concern about the absence of specific reference to neuropsychological testing and its application in the evaluation of claims of both adults and children with mental disorders. One spokesperson said that neuropsychological examinations are particularly relevant when neurodevelopmental or acquired brain dysfunction forms the basis of a person's category of disability. Another spokesperson said that proper evaluation of childhood brain insults requires comprehensive neuropsychological assessments because, "proper evaluation of these disorders requires assessments of specific skill domains such as would be provided in comprehensive neuropsychological assessments."

Response: We did not adopt these comments. We do not believe that it is necessary to refer to both psychological and neuropsychological testing because neuropsychological testing is a subset of psychological testing, and the same broad principles apply to our evaluation of these tests. In addition, neuropsychological test

batteries, while useful in clinical and research settings, have limited applicability in the disability program. This is because such batteries generally contain a number of subtests that focus on small units of behavior. These types of clinical measures often have little direct relevance to functional behavior as we assess it under the disability program. We will consider the results from neuropsychological assessments when they are a part of the evidence in the case record. We will not purchase formal neuropsychological test batteries, such as the Halstead-Reitan Neuropsychological Test Battery. We may purchase a neuropsychological test to assess specific neurocognitive deficits if the case evidence is insufficient to evaluate the claim, or to obtain evidence needed to resolve a conflict, inconsistency, or ambiguity in the evidence.

Comment: Spokespersons for some professional organizations recommended that we use symptom validity testing (SVT) to enhance validity of psychological consultative examinations (PCE) and to identify malingering. The commenters said that using SVT in disability evaluations is one method of enhancing validity, and they made two related recommendations. First, the commenter suggested that we consult with the American Academy of Clinical Neuropsychology and related organizations to take advantage of their expertise in revising and expanding provisions addressing symptom validity in the regulations. Second, the commenter suggested that we promote training in SVT methods or encourage change in PCE practice to include routine use of SVT to evaluate response bias, effort, and malingering during psychological examinations.

Response: We did not adopt the comment. Inaccurate self-report of symptoms

and behavior occurs when individuals, because of psychiatric disorders or personality traits, over- or under-report the nature, range, and severity of symptoms. Inaccuracy in self-report does not necessarily mean there is no medically determinable impairment that imposes real limitations. Since we do not adjudicate a claim based on symptoms alone, objective observation and description of the person's behavior must support any conclusions based on a test(s) of malingering. Additionally, the conclusions must be consistent with other evidence.

Sections 12.00D and 112.00D– How do we consider psychosocial supports, structured settings, living arrangements, and treatment? (Proposed 12.00F and 112.00F)

Comment: Several commenters asked that we make clear that the list of psychosocial supports and structured settings and living arrangements does not include all possible supports a person with mental disorder may receive, or in which he or she may be involved.

Response: We adopted the comment. We did not intend the list of supports in proposed 12.00F2 be inclusive of everything that we would consider when we evaluate a person's particular circumstances. We intended that the list only include examples of such supports and settings. In response to the comments, we added a phrase to final 12.00D1 indicating that the types of supports listed in that section are "some examples of the supports" that a person "may" receive.

Comment: Several commenters requested that we add supported housing with wrap-around services as an example of psychosocial supports and highly structured settings in proposed 12.00F2.

Response: We adopted the comment. We included reference to “‘24/7 wrap-around’ mental health services” to the examples of possible supports and structured settings and living arrangements in final 12.00D1d.

Comment: One commenter recommended that we expand the list of psychosocial supports and highly structured settings to include examples relevant to people whose impairments have contributed to homelessness and infrequent access to supports. The commenter said that the list of psychosocial supports, structured settings, and treatment presumes that a person has a regular and stable place to live, has social connections with family and friends, and has connections with treatment and services. However, clients of health care services for homeless people are often socially isolated, disconnected from services, and do not have a place to live, or live in residential facilities for homeless people.

Response: We adopted the comment. We added an example in final 12.00D1f to include the situation of people who receive assistance from a crisis response team, social workers, or community mental health workers who help them meet their needs and who may also represent them in matters with government or community social services.

Sections 12.00E and 112.00E–What are the paragraph B criteria? (Proposed 12.00C and 112.00C)

Comment: We received comments presenting several different reasons for retaining the prior paragraph B1 criterion, activities of daily living (ADL). The spokesperson for an organization was concerned that the proposed change to paragraph B1 will hinder accurate disability determinations for people with severe disabilities who do not regularly engage in work or treatment. This commenter said that the category of ADL is easily understandable to providers and that important information and significant details will be lost if this category is eliminated. Two commenters remarked that it is easier to document limitations in ADL than the proposed paragraph B1 criterion, particularly with respect to adults with mental disorders who are homeless and unable to access or attend consistent treatment. Another commenter said that if a person cannot adequately manage his or her ADL, it is reasonable to assume that working at substantial gainful activity levels would be extremely unlikely. One commenter said that removing ADL as a criterion partly ignores the basic self-reported information we have about what a person actually is doing while not in a work setting. Another commenter said that “as a non-clinician,” it is easier to see how someone is having a difficult time completing ADL than to give examples of when he or she does or does not “understand” things or “apply information.”

Response: We did not adopt these comments. However, we will continue to consider how a person performs ADL when we evaluate the effects of a mental disorder

on the person's functioning and ability to work. ADL information will continue to be central to our documentation of a person's mental disorder, because knowing how the mental disorder affects the person's day-to-day functioning can help us evaluate how it would affect the person's functioning in a work setting.

The final rules will use information about a person's ADL as a principal source of information, rather than as a criterion of disability. This change is congruent with the focus of the paragraph B criteria on the mental abilities a person uses to perform work activities. The principle is that any given activity, including ADL, may involve the simultaneous use of the paragraph B areas of mental functioning. For example, with respect to the same activity, one person may have trouble understanding and remembering what to do, while another person may understand the activity but have trouble concentrating and staying on task to do it. Still another person may understand the activity but be unable to engage in it with other people, or may feel such frustration in doing it that he loses self-control in the situation. Rather than ADL being one separate area in which we evaluate a person's functioning, ADL are now a source of information about all four of the paragraph B areas of mental functioning. We will focus on this aspect of the final rules in our formal training of adjudicators.

Comment: A commenter stated that the ADL information solicited from a person experiencing homelessness, along with third party evidence, is crucial to providing adjudicators with an accurate portrayal of limitations in daily functioning. A spokesperson for a professional organization raised concern that increased documentation

requirements would disproportionately affect homeless people with mental illness, because they do not have access to transportation to appointments, and face significant challenges in seeking treatment, attending appointments, and obtaining documentation. The spokesperson indicated that although homelessness is not an indication of functional limitation under the paragraph B criteria, a prolonged period of homelessness reflects significant barriers, such as a disabling condition, in obtaining and maintaining housing and health stability. The commenter suggested that it would be an oversight to ignore the most significant factor of a person's ADL (homelessness). A related comment was that it would be helpful to claimants and adjudicators if we provided examples of evidence we need from the person filing for disability benefits and from people who know him or her.

Response: We did not adopt the comments. As we explained in response to a previous comment, ADL information continues to be central to how we document a person's mental disorder and its effects on a person's daily functioning. Under these rules, we will use ADL as a source of information about all four of the paragraph B areas of mental functioning. We appreciate the unique difficulties that homeless people have with respect to access to transportation to appointments, and their significant challenges in seeking treatment, attending appointments, and obtaining documentation. We have special case processing and development guidance for homeless claimants in our field offices and our State agency partners in our sub-regulatory policies. Furthermore, we do not agree that these final rules increase documentation requirements. However, in final 12.00C5b, we included chronic homelessness as an example of a situation that may make it difficult to obtain longitudinal medical evidence.

Comment: The spokesperson for one organization said that it might be difficult to identify and distinguish sufficient information to satisfy the criteria in paragraphs B1 and B3, because the categories appear to be redundant. While proposed paragraph B1 (understand, remember, and apply information) involves a person’s cognitive abilities, proposed paragraph B3 (concentrate, persist, and maintain pace) involves attention. However, these two criteria have “significant overlap.” Medical records already lack sufficient functional information for disability determination, and moving to a more work-centered approach (using those criteria) may exclude some people.

Response: We did not make any changes to the final rules in response to these comments. We agree that there is “overlap” between the abilities to understand, remember, or apply information, and to concentrate, persist, or maintain pace—given the need to pay attention when using both abilities. It is also true that approaches to categorizing human abilities and functioning—in other contexts and for other reasons—use different categories to describe mental abilities. However, the Mental Cognitive Demands Subcommittee of the Occupational Information Development Advisory Panel (OIDAP) (referenced in the preamble to the NPRM) recommended separate categories and descriptions for “neurocognitive functioning,” and “initiative and persistence,”⁴ which generally parallel the final paragraphs 12.00E1 and 12.00E3 criteria, respectively.

⁴ Occupational Information Development Advisory Panel (OIDAP) under the Federal Advisory Committee Act. Mental-Cognitive Subcommittee Content Model and Classification Recommendations. Report of the Mental-Cognitive Subcommittee, Appendix C, C-15 and C-16. September 2009. <https://www.ssa.gov/oidap/Documents/AppendixC.pdf>.

In our prior rules on evaluating mental disorders, there is precedent for using the two separate paragraph B criteria to evaluate a person's functioning. Since 1990, in the rules for evaluating mental disorders in children, we have used separate criteria for assessing a child's cognitive functioning and the child's concentration, persistence, and pace (see 112.00). Since 1991, the rules for assessing a claimant's mental residual functional capacity (MRFC) have specifically addressed non-exertional limitations, including limitations in the person's ability to understand or remember instructions and to maintain attention or concentration (see §§ 404.1569a(c) and 416.969a(c)). Our programmatic experience has been that when a person's difficulties with the abilities described in paragraphs B1 and B3 rise to the level of marked limitation, the medical and non-medical evidence in the record is typically sufficient to distinguish the person's limitations in those abilities.

Comment: Many commenters were concerned that our use of "and" in proposed paragraph B1 (understand, remember, and apply information) and proposed paragraph B3 (concentrate, persist, and maintain pace) could be misinterpreted as a change in policy that would set a higher standard for a person's mental disorder satisfying those criteria. The misinterpretation would be that a claimant would have to demonstrate limitation in each of the three parts of B1 and B3 rather than in only one part. The commenters recommended that we change the word "and" to "or" in B1 and B3 for all of the listings. They also recommended that we make clear in the 12.00 Introduction that if a person has "extreme" or "marked" limitation in any single part of the B1 or B3 areas of mental functioning, the person has that degree of limitation for that whole paragraph B criterion.

Response: We agree with the commenters and the reasons they provided.

Therefore, we adopted these recommendations. To ensure that adjudicators apply these criteria properly, we explain in new sections, final 12.00F3f and 112.00F3e, that for paragraphs B1, B3, and B4, the greatest degree of limitation of any single part of the area of mental functioning will direct the rating of limitation for that whole area of functioning.

Comment: Several commenters expressed concern about the new paragraph B4 criterion, manage oneself. Two commenters said that the criterion is “vague and very difficult to document . . . and open to extremely subjective interpretation.” They further commented that the proposed criterion of “manage oneself in a work environment” is “undefined and very subjective.” Another commenter said, “self-management and skills for independence encompass more than the workplace and this should not be the requirement.” The spokesperson for an organization questioned the usefulness of “managing oneself in a work environment” as a separate paragraph B criterion because this “appears to be the overarching question when evaluating functional limitations; this is precisely what the four functional areas attempt to assess.”

Response: We partially adopted the comments. In these final rules, we made changes to paragraph B4 to clarify the abilities and behaviors that the criterion “managing oneself” encompasses. We added more examples of “managing oneself” in the workplace in final 12.00E4, such as distinguishing between acceptable and

unacceptable work performance, setting realistic goals, and making plans independently of others. Another change we made was adding that a person's ability to maintain personal hygiene and attire should be appropriate to a work setting. After making these revisions, we changed the title to include the word "adapt" to reflect the abilities and behaviors that we consider for this criterion.

Additionally, we note that the content of the B4 criterion is not new or different from what adjudicators are already accustomed to evaluating and documenting. Our adjudicators already consider a person's ability to respond appropriately to work pressures when they assess the nature and extent of a person's mental limitations and determine the person's residual functional capacity for work activity (see §§ 404.1545(c) and 416.945(c)).

With respect to the comment that self-management and skills for independence encompass more than the workplace, we agree that the ability and skills we address in paragraph B4 are important in daily life as well as the workplace. The statutory definition of disability for adults limits our determination to whether a person is able to work (and, therefore, function in the workplace). However, we use all the information available to us about how a person functions, including how the person manages him- or herself from day-to-day at home and in the community, to make this determination.

Comment: A spokesperson for an organization expressed concern that eliminating "repeated episodes of decompensation" from the paragraph B criteria would

reduce our ability to measure the chronic nature and impact of a mental illness. The commenter noted that evaluating a person's decompensation patterns over time is crucial for determining the full impact of a mental disorder. The commenter also said that current medical records, particularly those for people with transient treatment, provide only a momentary snapshot of the illness.

Response: We did not adopt these comments. We do not agree that eliminating "episodes of decompensation" from the paragraph B criteria will reduce our ability to measure the chronic nature and impact of a mental illness. To address the chronic nature of a mental disorder, we provide guidelines in several sections of the final rules: final 12.00C5, concerning the need for longitudinal evidence; final 12.00F4, concerning how we evaluate disorders involving exacerbations and remissions; and final 12.00G and the paragraph C criteria, which address "serious and persistent" mental disorders.

Comment: One commenter found the proposed definitions of the B criteria lacking in detail and examples to guide adjudicators and advocates, particularly when compared to our prior rules. Another commenter said that the proposed B2 criterion for interacting with others was too broad, and difficult to assess and use in determining a person's mental status. The commenter said it would be more helpful if we were to provide examples of more specific interpersonal behaviors that reflect how one handles conflicts in adaptive, compared with maladaptive and impaired, ways.

Response: We adopted these comments. We included more examples of each of

the criteria in final 12.00E to provide adjudicators a more detailed understanding of the four paragraph B criteria in these final rules. We included the example of “keeping social interactions free of excessive irritability, sensitivity, argumentativeness, or suspiciousness” in our explanation of paragraph B2 to describe an adaptive way to interact socially in the context of maladaptive examples of social interactions.

Sections 12.00F and 112.00F–How do we use the paragraph B criteria to evaluate your mental disorder? (Proposed 12.00D and 112.00D)

Comment: Many commenters representing various organizations, health care professionals, families of people with mental disorders, and others opposed the language in proposed 12.00D regarding using standardized test results to inform our assessment of whether a claimant’s impairment results in marked or extreme limitations of his or her mental abilities. Commenters expressed a wide array of opinions and recommendations; the most frequently made public comment was, “the proposed use of standardized tests to measure the functioning of people with serious mental illnesses is a flawed approach, with no scientific basis.”

Response: In response to these comments, we removed this provision in the final rule. We had included the language in proposed 12.00D based on comments that we received in response to the ANPRM. In the ANPRM, we invited the public to send us comments and suggestions for updating and revising the mental disorders listings. In response to the ANPRM, two major organizations representing people with cognitive and

other mental disorders advised that, in revising rules for mental disorders in adults, we should incorporate the definitions of “marked” and “extreme” limitations based on standardized test results that we have in the childhood disability regulations in § 416.926a(e) of this chapter. In response to that recommendation, and as explained in the NPRM, we included these provisions from the childhood rules in proposed 12.00D (75 FR 51341-42). However, in their comments on the 2010 NPRM, those same organizations, and many other commenters, presented the objections summarized above about using the childhood regulatory definitions of “marked” and “extreme” based on the results of standardized testing.

In these final rules, we removed the provisions and explanations that were in proposed 12.00D. We provide guidance that is different from what we proposed in 12.00D in final 12.00F (How do we use the paragraph B criteria to evaluate your mental disorder?). Final 12.00F explains how we rate the degree of a person’s limitations when using the four paragraph B areas of mental functioning. For example, we provide a five-point rating scale, with definitions of each point on the scale that are unrelated to standardized test results. We explain how we use the paragraph B criteria and the rating scale to evaluate a person’s ability to function independently, appropriately, and effectively, on a sustained basis.

Comment: A spokesperson for an organization stated that psychometric tests should not be the sole determinant of “marked” and “extreme” limitation for children. The commenter said that we should base our determination of the level of a child’s

limitation on the overall clinical assessment of the child, with equal emphasis placed on both testing and clinical assessment.

Response: We do not rely on test scores alone when we decide whether a child is disabled. As explained in § 416.924a, when we determine disability, we consider all of the relevant information in a child's case record. We do not consider any single piece of evidence, including test scores, in isolation. The medical evidence we consider includes clinical observations from, for example, a child's physician, psychiatrist, psychologist, or speech-language pathologist, and from other medical sources such as physical, occupational, and rehabilitation therapists. These sources of evidence may provide us their clinical assessments of a child's impairment(s) and its effects on the child's functioning. Professional sources such as teachers and school counselors, as well as the child's caregivers and others who know the child, also provide information important to any disability determination.

Comment: Many commenters recommended that we use a 5-point or 6-point scale to evaluate impairment severity. Some commenters supported use of a 5-point scale "to assist disability examiners to anchor the standards of 'marked' or 'extreme' limitations in functioning." Others submitted a rationale for using a 6-point scale, saying that a 5-point scale defined by "no" limitation at one end and "extreme"—but not total—limitation at the other is confusing and misleading. They recommended that, to provide more clarification to adjudicators and medical sources, we should use a 6-point scale consisting of: no limitation; slight limitation; moderate limitation; marked limitation;

extreme limitation; and total limitation.

Response: We adopted the recommendation to retain the 5-point rating scale from our prior rules to assess impairment severity for adults. We agree that the use of this scale will help “anchor” the standards of “marked” and “extreme.” We provide definitions for each of the points of the scale in final 12.00F2. With respect to the recommendation that we use a six-point scale to evaluate impairment severity (that is, the addition of a sixth point at the “severe” end of the 5-point scale), we disagree that such a scale “would provide more clarification to adjudicators and medical sources.” “Extreme” is the rating we give to the worst limitations; however, it does not mean a total lack or loss of ability to function. A sixth rating point of “total limitation” would not serve any useful function in the disability program.

Comment: The spokesperson for an organization recommended that we use the term “mild” to describe the second point on the five-point scale for assessing the degree of a person’s limitations. The commenter objected to the term “slight,” as suggested in proposed 12.00D. The commenter stated that professionals use the term “mild” when rating and ranking human behavior.

Response: We adopted the comment. As discussed above, because we are retaining our prior policies pertaining to the use of a five-point scale in these final rules, we will continue to use the word “mild” to describe the second point on the scale. By using the same words to describe the same policies, we hope to prevent any confusion

that would result from using a new and different word.

Comment: The spokesperson for an organization requested “additional clarification that it is not the role of the adjudicator to evaluate a claimant’s ability to function in the workplace based on his or her own conclusions drawn from a single observation of the claimant.”

Response: We did not adopt the comment. We do not believe the additional clarification that the commenter requested is necessary in these final rules. The introductory text states in multiple places that we will consider all relevant evidence when we evaluate a person’s ability to function in the workplace. Final section 12.00F3a states that we will use all of the relevant medical and non-medical evidence in the case record to evaluate a person’s mental disorder. In final section 12.00F3c, we indicate that we will consider all evidence about a person’s mental disorder and daily functioning before we reach a conclusion about his or her ability to work. In final 12.00F3d, we state that no single piece of information can establish the degree of limitation of a paragraph B area of mental functioning. We do not believe the additional statement requested by the commenter is necessary in light of the other guidance throughout final 12.00F.

Comment: Several commenters suggested that we consider homelessness (along with a diagnosis of mental illness) as an indicator of functional impairment. The commenters also proposed that we could establish a period of homelessness that we would consider an indicator of functional difficulty.

Response: We did not adopt the comment. When we evaluate a person's mental disorder(s), we consider all the information available to us that could indicate limitations in the person's functioning. If the person is homeless, we consider that fact, including how long he or she has been homeless. As stated in final 12.00C5b, we try to learn about how a person functions day-to-day from the people who spend time with him or her. However, it would not be appropriate to establish a specific period of homelessness as an indicator of limited functioning, because we do not believe there is a measurable correlation between the severity of a person's mental disorder and the length of time the person has been homeless.

Comment: A commenter requested that we place a greater emphasis on a claimant's ability to sustain work activity for 8 hours per day, five days per week, on a regular and continuing basis.

Response: We adopted the comment. In final 12.00F4a, where we discuss how we evaluate mental disorders involving exacerbations and remissions, we explain that we will consider whether a person can use his or her areas of mental functioning on a regular and continuing basis (8 hours a day, 5 days a week, or an equivalent work schedule).

Comment: The spokesperson for an organization recommended that we change our policies so that a "moderate" degree of impairment in three or more areas of functioning demonstrates an individual's inability to work.

Response: We did not adopt the comment. It has been our longstanding policy to require that a claimant have “marked” limitation in two areas of functioning or “extreme” limitation in one area of functioning to be found disabled at the third step of the sequential evaluation process. At this step, we consider whether the person’s impairment meets or equals a listed impairment.⁵ In other words, the impairment must be “severe enough to prevent an individual from doing any gainful activity, regardless of his or her age, education, or work experience” (or, for a child under age 18 for title XVI eligibility, the impairment causes “marked and severe functional limitations”).⁶ Our programmatic experience includes the use of a standard based on moderate limitations in three domains in the title XVI childhood disability program from February 11, 1991 through August 21, 1996.⁷ We used this standard at a fourth step of the childhood sequential evaluation process, not at the third step.⁸ In our experience with this standard, the spectrum of limitation that may constitute “moderate” limitation ranges from limitations that may be close to “marked” in severity to limitations that may be close to the “mild” level. Thus, people who have moderate limitation in three or more functional areas do not always meet our definition of disability. We assess these types of claims most accurately at the fourth step of the sequential evaluation process, where we consider a claimant’s residual functional capacity and work experience, and the fifth step of the sequential evaluation process, where we also consider a claimant’s age and education.

⁵ §§ 404.1520, 416.920, and 416.924.

⁶ §§ 404.1525(a) and 416.925(a).

⁷ See 56 FR 5560 for the regulation in effect from February 11, 1991, through September 8, 1993, and 58 FR 47584 for the regulation in effect from September 9, 1993, through August 21, 1996.

⁸ The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 eliminated this standard and the fourth step of the childhood sequential evaluation process (Pub. L. 104-193).

Comment: Several commenters were concerned that a clinician’s use of the term “mild” or “moderate” in diagnosing the stage or level of a person’s mental disorder (for example, as in a diagnosis of Alzheimer’s disease) might be misconstrued as a description of the person’s level of functioning with respect to the paragraph B or C criteria. They suggested that we include language in 12.00 to preclude any misunderstanding of how medical providers use these terms in medical records. Presenting the opposite viewpoint, one commenter recommended that we incorporate the DSM-IV-TR definitions for “mild,” “moderate,” and “severe” in these rules as our program definitions for “mild,” “marked,” and “extreme.”

Response: We adopted the first comment for the reason the commenters provided. We added the recommended language to final 12.00F3a. We did not adopt the second comment for three reasons. First, the definitions of the terms “mild,” “moderate,” and “severe” in the updated DSM-5 are different depending on the type of mental impairment the words are describing. For example, the DSM-5 definition of “mild” to describe major neurocognitive disorder is different from the definition of “mild” to describe major depressive disorder, and different from the definition of “mild” to describe intellectual disability. The different definitions of these terms in the DSM-5 serve the needs of trained medical and psychological specialists. However, they would be confusing and burdensome for our adjudicators to use.

Second and related to the first point above, the DSM-5 does not use the terms

“mild,” “moderate,” and “severe” consistently for all of the types of mental disorders. For example, the DSM-5 does not use the words “mild,” “moderate,” or “severe” to describe anxiety disorders. In addition to these three words, the DSM-5 also uses the word “profound” to describe some cases of intellectual disability. As a result, if we were to rely on the DSM-5 definitions of these terms, we would not have definitions for all types of impairments. The DSM-5 definitions are not comprehensive enough for our program purposes.

Third, we have used the words “mild,” “moderate,” “marked,” and “extreme” under our prior rules for many years. Although we did not provide definitions for most of these terms until now, the definitions in final 12.00F are consistent with how our adjudicators have understood and used those words in our program since we first introduced the rating scale in 1985. As a result, the definitions we provide in these rules do not represent a departure from prior policy. However, the DSM-5 definitions for these terms are not consistent with how we have used these words in our program in the past. For example, a claimant who has “mild” intellectual disability according to the DSM-5 may have “moderate” or “marked” limitation in understanding, remembering, or applying information, depending on the facts of the case. We believe that using familiar definitions and concepts to define familiar terms will be easier for the public and adjudicators, rather than describing familiar terms in changed and unfamiliar ways.

For these three reasons, we did not adopt the second recommendation.

Comment: A commenter recommended that we add language to proposed 12.00F and 112.00F to explain how adjudicators assess claims involving psychosocial supports and highly structured settings.

Response: We adopted the comment. We added final sections 12.00F3e and 112.00F3d to explain how we consider the effects of support, supervision, and structure when we rate the degree of limitation that a person has. We explain that the more extensive the support the person needs from others, or the more structured the setting the person needs in order to function, the more limited we will find him or her to be.

Sections 12.00G and 112.00G—What are the paragraph C criteria, and how do we use them to evaluate your mental disorder? (Proposed 12.00E and 112.00E)

Comment: We received various comments regarding our proposal to use the term “deterioration” rather than “decompensation” in the paragraph C criteria of the listings. Commenters who opposed the change cited confusion and negative connotations associated with the word “deterioration.” Commenters who agreed with the change stated that “decompensation” refers to a state of extreme deterioration often leading to hospitalization. They further noted that a person with a serious and persistent mental illness does not need to be in a state of full-blown decompensation to have serious deficits in daily activities and in social or occupational functioning. Another commenter recommended that we keep some of the examples in prior 12.00C4 to explain what we mean by “deterioration”; for example, increase or change in medication, more help from

others to support the person's functioning, or the need to live in a controlled environment.

Response: We did not adopt the suggestion to use the term “decompensation.”

We agree with the majority of comments that we received in response to the NPRM supporting our proposal to use “deterioration.” As we noted in the NPRM,⁹ “decompensation . . . refers to a state of extreme deterioration, often leading to hospitalization.” It also suggests that the person is a danger to him- or herself or others. That degree of impairment exceeds what we generally intend in the paragraph C criteria when we refer to the “marginal adjustment” that makes a person vulnerable to deterioration in functioning. Furthermore, we also believe that continuing to use “decompensation” may result in confusion between the prior rules and these final rules. In these final rules, we no longer require “repeated episodes of decompensation, each of extended duration.”¹⁰ We agree with the comment that some of the examples in prior 12.00C4 help explain what we mean by “deterioration.” We adopted that comment, and we included examples in final 12.00G2c.

Comment: One commenter was concerned that the emphasis in proposed 12.00E2b on continued treatment or highly structured settings would not be flexible enough to evaluate certain phobic conditions, such as agoraphobia, the symptoms of which often preclude such treatment. The commenter suggested that proposed 12.00F2 should state that the circumstances in paragraph C1 are not exhaustive, and that we

⁹ See 75 FR 51338.

¹⁰ In our prior rules, this requirement was in the B4 criterion in all of the listings except 12.05. In prior 12.05, the requirement was in the D4 criterion. It was also in the C1 criterion in prior 12.02, 12.03, and 12.04.

consider other types of supportive services, including in the home.

Response: We adopted the comment. We added language to final 12.00D1 to indicate that the list of psychosocial supports, structured settings, and living arrangements are only examples of supports that a person may receive. Both proposed 12.00F2 and final 12.00D1 include the home of a person who lives alone and has eliminated all but minimally necessary contact with the outside world as an example of a “highly structured environment.” We intended this example to apply to persons with phobic conditions, such as agoraphobia.

Comment: One commenter was concerned that the paragraph C criteria, and the description of the criteria in proposed 12.00E, did not account for a claimant’s lack of insight or awareness about his or her mental disorder. The commenter stated that many people with mental disorders lack awareness about their mental disorders and therefore refuse treatment. The commenter recommended that the policies should not place at a disadvantage those claimants whose mental disorders cause them to refuse to attend or follow up with treatment.

Response: We agree with the commenter’s reasoning, and we adopted the recommendation. We added language in final 12.00G2b stating that we will consider periods of inconsistent treatment or lack of compliance with treatment that may result from a claimant’s mental disorder. The section explains that if the evidence indicates that the claimant’s inconsistent treatment or lack of compliance is a feature of his or her

mental disorder, and it has led to an exacerbation of his or her symptoms and signs, we will not use it as evidence to support a finding that the claimant has not received ongoing medical treatment.

Sections 12.00H and 112.00H—How do we document and evaluate intellectual disorder under 12.05 (112.05)?

Comment: Several commenters were concerned that proposed 12.00D4 would allow disability decision-makers to reject standardized test scores based on their subjective opinions of a person's day-to-day functioning. The commenters also stated that the language in this section would give an inappropriate amount of discretion to the adjudicators, who do not have the expertise of the test administrators. They cited two examples of possible rejection of "valid test scores": When a person's daily functioning is actually very basic or supported by others; or when a person's strengths in one area are used to find that the person's test results or limitations in another area are "not credible." These commenters asked us to state clearly that interpretation of a test is primarily the responsibility of the professional who administered the test, and that adjudicators cannot override the validity of a medical professional's interpretation of test results.

Response: We adopted most of these comments by making several changes in the final rules. First, we removed the discussion of evaluating test scores from final 12.00F, which replaces proposed 12.00D. Like proposed 12.00D, final 12.00F provides guidance to adjudicators about how to evaluate a claimant's functioning using the "paragraph B"

areas of mental functioning. However, final 12.00F does not include a discussion of standardized test scores. Second, we added a new section, final 12.00H, to organize and expand the guidance to adjudicators about how to evaluate a cognitive impairment under listing 12.05. We moved the discussion about standardized test scores into final 12.00H2 because only listing 12.05B requires standardized test scores.

Third, we revised the guidance to indicate that only qualified specialists, Federal and State agency medical and psychological consultants, and other contracted medical and psychological experts, may conclude that an obtained IQ score(s) is not an accurate reflection of a claimant's general intellectual functioning. This change serves several purposes. It responds to the commenters' concern that proposed 12.00D gave an inappropriate amount of discretion to the adjudicators who do not have the expertise of the test administrators by permitting only the individuals who do have the expertise of test administrators to make conclusions about IQ scores. However, it also allows our agency's medical and psychological experts to reach different conclusions than those reached by the individual test administrator, when appropriate. This option is important because during our case development, we often receive a more complete picture of a claimant's functioning from a variety of sources of information other than the test administrator(s).

Comment: Some commenters said that the proposed rules were "weak with respect to specifying the standard of practice in psychometric evaluations." The commenters recommended stronger language calling for the use of standardized

instruments “with comprehensive and representative norms, for which there is empirical evidence for construct and criterion validity in the demographic and diagnostic groups in which they are used.”

Response: We partially adopted the comments. The proposed rules removed the detailed information on psychological testing in prior 12.00D5 through D9 because, as we explained in the NPRM, most of the information is educational and procedural, and tests are regularly revised and updated. However, in these final rules, we added section 12.00H2 to explain the evidence that we require from standardized intelligence testing under final listing 12.05B. In this section, we included the information from prior 12.00D5 and D6 that applies to intelligence tests. In addition, we expect to provide formal and accessible guidance to adjudicators about intelligence testing and final listings 12.05 and 112.05. We discuss why we do not require standardized assessments of adaptive behavior in our response to another comment below.

Comment: A commenter stated that sometimes people with intellectual disability are not properly identified because they “appear more functional than they are,” particularly in work settings. The commenter requested that we consider “on the job difficulties” as part of our analysis of a person’s adaptive functioning.

Response: We adopted the comment. As discussed above, we added final 12.00H to expand the guidance to adjudicators about how to evaluate a cognitive impairment under listing 12.05. That section includes a sub-section about how we

consider a claimant's work activity when we evaluate his or her functional abilities. We state that we will consider all factors involved in a claimant's work history, including whether the work was in a supported setting, whether the claimant required additional supervision, how much time it took the claimant to learn the job duties, and the reason the work ended, if applicable.

Comment: The spokespersons for several organizations recommended that we further clarify how adjudicators will evaluate deficits in adaptive functioning. One commenter suggested that we mention standardized tests as a valuable source of evidence. Another commenter recommended that we evaluate and rate deficits in adaptive functioning in terms of scores that are two or more standard deviations below the mean. The commenter asserted that this measurement would be "consistent with the drafted criteria for Intellectual Disability under DSM-5 and would better reflect the desired increase in focus on adaptive behaviors consistent with current trends set by the American Association on Intellectual and Developmental Disabilities [AAIDD]." The commenter also thought that use of standard scores to evaluate adaptive functioning would simplify listing 12.05.

Response: We adopted the suggestion to provide more clarification about how adjudicators will evaluate deficits in adaptive functioning. As we discussed earlier in this preamble, the reorganized criteria in final listings 12.05A and 12.05B describe the evidence that we require to establish significant deficits in adaptive functioning for each listing. Final 12.05A2 requires dependence upon others for personal needs (for example,

toileting, eating, dressing, or bathing) to establish significant deficits in adaptive functioning. Alternatively, final 12.05B2 requires extreme limitation of one, or marked limitation of two, of the “paragraph B” areas of mental functioning. The revised organization of final listings 12.05A and 12.05B enabled us to provide these specific, concrete criteria. We then added final section 12.00H3 to provide more guidance about adaptive functioning generally, and adaptive functioning in specific situations, such as when a claimant with intellectual disability has a work history. Furthermore, we included “standardized tests of adaptive functioning” as an example of evidence we may receive and consider about a claimant’s adaptive functioning in final 12.00H3b.

We did not adopt the suggestion to evaluate and rate deficits in adaptive functioning in terms of scores that are two or more standard deviations below the mean. We are aware that for the AAIDD, “. . . significant limitations in adaptive behavior are operationally defined as performance that is two standard deviations below the mean of either (a) one of the following three types of adaptive behavior: conceptual, social, or practical, or (b) an overall score on a standardized measure of conceptual, social, and practical skills.”¹¹ The AAIDD also provides guidelines concerning technical standards for adaptive behavior assessment instruments and for selecting an adaptive behavior assessment instrument.

However, the use of standard deviations as a required measure of deficits in adaptive functioning under listing 12.05 is not feasible or necessary in our program. The

¹¹ American Association on Intellectual and Developmental Disabilities: Intellectual Disability: Definition, Classification, and Systems of Supports, 11th Edition, Washington, D.C., 2010, page 43.

suggestion is not feasible because inclusion of such criteria in the listing would mean that we would have to require the results of a standardized test of adaptive functioning in every case evaluated under that listing. Although we can agree with the recommendation in principle, the medical evidence of record for claims that we would evaluate under listing 12.05 do not always contain adaptive functioning test results. Financial constraints within the disability program preclude our purchasing such testing in every case lacking such results.

Additionally, the suggestion is unnecessary because the areas of mental functioning described in the 12.00 “paragraph B” criteria capture both the spirit and intent of the AAIDD’s descriptions and understanding of the elements of adaptive functioning. For that reason, as for all other mental disorders, we use the paragraph B areas of mental functioning to evaluate the limitations in a person’s adaptive functioning under listing 12.05. We explain in final 12.00H3 that if a person’s case record includes the results of a standardized test of adaptive functioning, we will consider the test results along with all other relevant evidence. However, to evaluate and determine the severity of those deficits, we will use the guidelines in final 12.00E, F, and H.

Sections 12.00I and 112.00J—How do we evaluate substance use disorders? (Proposed 12.00H and 112.00H)

Comment: Several commenters requested that we more clearly define the criteria and guidelines for determining the nature and effects of substance use on a person’s

functional capacity.

Response: This request is outside the scope of the notice of proposed rulemaking, and we did not adopt this comment in these final rules. However, we appreciate the importance of clear guidance for implementing the statutory drug addiction and alcoholism (DAA) policy. Therefore, we published a Social Security Ruling (SSR) titled, “Social Security Ruling, SSR 13-2p.; Titles II and XVI: Evaluating Cases Involving Drug Addiction and Alcoholism (DAA))” on February 20, 2013.¹² We based the SSR on information we obtained from individual medical and legal experts, the Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Human Services, and our adjudicative experience. The SSR provides detailed guidance for adjudicators at all administrative levels. It consolidates information from our regulations, training materials, and question-and-answer responses to explain our DAA policy.

In cases of alleged mental impairment in which a substance use disorder is involved, we will evaluate the person’s mental impairment, as appropriate, under the mental disorder listing for the involved condition (for example, depressive, bipolar and related disorders; schizophrenia spectrum and other psychotic disorders), and according to the guidelines in SSR 13-2p.

Listings 12.05 and 112.05–Intellectual disorder

¹² See 78 FR 11939. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2013-02-20/pdf/2013-03751.pdf>.

Comment: We received many comments on the proposed change in the name of listing 12.05 to “intellectual disability/mental retardation (ID/MR).” Most commenters requested that we use only “intellectual disability,” given the adoption of that name in other governmental and non-governmental contexts. Some commenters were satisfied with the combination of terms during a transitional period, given our rationale in the NPRM for using both terms until the public and our adjudicators become accustomed to “intellectual disability” alone. One commenter, acknowledging a minority opinion, argued that we ought not to eliminate use of the prior title at any time. Several other commenters, while favoring the idea of changing the name of the listing, did not endorse the term proposed in the NPRM. Instead, they recommended the term, “intellectual disorder,” because use of the word “disability” in the name of a listing would be confusing to claimants and to our adjudicators.

Response: We adopted the last suggestion. After the NPRM published in 2010, Congress passed Public Law 111-256, which changed historically used terms in certain Federal laws to their updated counterparts, such as “intellectual disability” and “an individual with an intellectual disability.” The Federal law ordering this change did not apply to titles II and XVI of the Act, and therefore, did not require us to make any changes to our regulations. However, in response to public requests and in the spirit of the new law, we published another NPRM on January 28, 2013 (78 FR 5755). The NPRM proposed to replace the historically used term with “intellectual disability” in our prior listings and in other appropriate sections of our rules. Public comments in response to the 2013 NPRM generally supported the change in terminology, and the proposed

change became a final rule on August 1, 2013 (78 FR 46499).

However, we are unlike other Federal agencies that have adopted the new terminology “intellectual disability” because we must comply with a legal definition of the word “disability.” As a result, a person who has a cognitive impairment, including intellectual disability, does not have a “disability” within the meaning of the Act until we have determined that the impairment satisfies all of the statutory and regulatory requirements for establishing disability.

Although we carefully considered all of the comments we received in response to the 2010 NPRM, we ultimately agreed with those commenters who, while favoring the idea of changing the name of the listing, recommended the name “intellectual disorder” for listings 12.05 and 112.05. We agree with their perspective and their recommendation, and we have adopted their proposed name change.

Comment: Some commenters, including the spokesperson for a national organization, recommended that we make changes to listing 12.05. Commenters criticized the listing structure proposed in the NPRM as “inconsistent, redundant and unnecessary.” One commenter stated, “the severity of intellectual disability is written into the diagnosis itself.” Another commenter criticized proposed listing 12.05B as being both unclear and “not needed.” Some commenters said that proposed listing 12.05C is “unnecessary.” The commenters recommended that listing 12.05 guide adjudicators on the process of establishing intellectual disability with the assessment of both intellectual

functioning and adaptive behaviors.

Response: We adopted the comments. We reorganized the requirements of listing 12.05 to reflect the three diagnostic criteria for intellectual disability from the DSM-5 and the AAIDD. Listing 12.05 now has two paragraphs: 12.05A for claimants whose cognitive limitations prevent them from being able to take a standardized intelligence test and 12.05B for claimants who are able to take a standardized intelligence test. Paragraphs 12.05A and 12.05B each have three criteria that match the diagnostic criteria for intellectual disability and that describe the evidence that we need to satisfy the criteria. A claimant's impairment must satisfy the three criteria in either paragraph 12.05A or 12.05B, not both. We provide additional explanation about the revisions to listing 12.05 later in this preamble.

Comment: Several commenters thought that proposed 12.00B4d would give “excessive and largely unbridled leeway to the adjudicator to override valid test findings.” The language they objected to was, “We consider your IQ [intelligence quotient] score to be ‘valid’ when it is supported by the other evidence, including objective clinical findings, other clinical observations, and evidence of your day-to-day functioning that is consistent with the [intelligence] test score.” The commenters said that “. . . the proposed rule seems to create a third prong to establish the diagnosis” of intellectual disability. They identified the third “prong” as “evidence of your day-to-day functioning that is consistent with the test score.” The commenters urged us to ensure that adjudicators respect “a valid diagnosis of ‘intellectual disability’” made by

professionals and not allow adjudicators to dismiss a valid diagnosis.

Other commenters thought that proposed 12.00B4d would allow adjudicators to use “virtually . . . anything as evidence of a level of functioning that is inconsistent with” intellectual disability. An attorney who represents disability claimants indicated that adjudicators cite “high adaptive scores, or virtually anything in the record, as evidence of a level of functioning that is inconsistent” with intellectual disability.

Response: We made several changes in these final rules in response to these comments. First, as we mention in our response to an earlier comment, we revised the criteria in listings 12.05A and 12.05B. The changes clarify that there are three criteria that must be satisfied in order for an impairment to meet one of these listings. The three criteria, restated here, are: 1. significantly subaverage general intellectual functioning, 2. significant deficits in adaptive functioning, and 3. evidence demonstrating or supporting the conclusion that the disorder began prior to age 22. For claimants who are able to take a standardized intelligence test, the listing criteria about daily functioning requires that the claimant’s impairment result in significant deficits in adaptive functioning, evidenced by extreme limitation in one, or marked limitation in two, of the four paragraph B areas of mental functioning (see final 12.05B2). This new organization of the listing criteria makes clear that there is no criterion or “prong” requiring “evidence of your day-to-day functioning that is consistent with the [intelligence] test score” to establish disability. We discuss the revisions we made to listing 12.05 in detail in a later section of this preamble.

Second, we removed proposed 12.00B4d, and we added final 12.00H to expand and organize the guidance for documenting and considering evidence under final listing 12.05. In final 12.00H2, we state that we will find standardized intelligence test results usable when a qualified specialist has individually administered the test. We indicate that only qualified specialists, Federal and State agency medical and psychological consultants, and other contracted medical and psychological experts may conclude that an obtained IQ score(s) is not an accurate reflection of a person's general intellectual functioning. The conclusion of the qualified specialist, or medical or psychological consultant or expert, about the accuracy of the obtained IQ score(s) determines whether the person's cognitive impairment satisfies the IQ score criterion.

Third, in response to concerns that an adjudicator might misinterpret information about a person's daily functioning, we included guidance in three sections of the final rules to ensure proper evaluation of that information. In final 12.00D3, which applies to all of the mental disorders listings, we explain how we consider the complete picture of the person's day-to-day functioning, including the kinds, extent, and frequency of help and support received. In final 12.00H3d, which applies to final listing 12.05B, we discuss how we consider evidence that a person engages in commonplace everyday activities when we evaluate his or her adaptive functioning. We state that a person may demonstrate both strengths and deficits in adaptive functioning, and we cite examples of the kinds of commonplace activities that a person might engage in. In final 12.00H3e, which also applies to final listing 12.05B, we discuss how we consider evidence that a person engaged in work when we evaluate his or her adaptive functioning. We describe

special circumstances that may have made it possible for the person to work. In these two sections, we explain that we will not assume that doing some commonplace activities or work activity demonstrates that the person’s impairment does not satisfy the criteria in 12.05B.

Regarding the request to ensure that adjudicators respect “a valid diagnosis of ‘intellectual disability,’” we did not adopt this comment. It has been our experience that there can be considerable variability in the quality of reports of psychological examinations and intelligence testing. Moreover, our mental disorders listings are function-driven, not diagnosis-driven. To address this situation, and for the reasons explained in other sections of the preamble, we believe that the revision to listing 12.05 is a simpler, more effective approach to evaluating intellectual disability. The three elements that define “intellectual disability” are the three criteria in listing 12.05. We do not use the word “diagnosis” in the rules related to the listing.

Comment: The spokesperson for an organization recommended that we change the term “mental incapacity” to “intellectual incapacity” in proposed 12.05A. The commenter suggested this change to be consistent with the reference to “intellectual functioning” later in proposed 12.05A.

Response: We adopted the comment, in part. We removed the term “mental incapacity” from final 12.05A, as suggested. However, as part of the overall reorganization of listing 12.05, we replaced “mental incapacity” with the phrase

“significantly subaverage general intellectual functioning.” We use this phrase to describe the first criteria in both listings 12.05A and 12.05B because it is a more accurate description of the first element of the medical definition of intellectual disability as defined in the DSM-5 and by the AAIDD, discussed above.

Comment: We received differing public comments regarding the appropriate IQ score we should use for determining whether a person has significantly subaverage general intellectual functioning. Some commenters supported the continued use of the lowest IQ score (such as a part score, or component score) on a test that provides more than one score. Others questioned why we would use a part score rather than the full scale IQ score. The spokesperson for a professional organization noted, “the Full Scale IQ is a widely understood and useful summary measure of intellectual functioning.” Another commenter said that use of the lowest part score is inconsistent with other accepted definitions of intellectual disability, including that of the AAIDD and that of the DSM-IV-TR. These definitions call for the use of the full scale IQ score, except in limited circumstances. The commenter also noted that use of a part score could result in an outcome inconsistent with the definition of the disorder, which requires proof of “significantly subaverage general intellectual functioning [emphasis in original].” Other commenters questioned why we did not adopt the 2002 recommendation of the National Research Council to generally use the full scale IQ score, and to use certain part scores in limited circumstances.

Response: We partially adopted these comments. We agreed with the reasons

provided by the commenters who suggested that we use a full scale IQ score to determine whether a person's cognitive impairment satisfies the criteria in final listings 12.05B and 112.05B. In our experience, full scale IQ scores are the most reliable evidence that a person has intellectual disability and not another impairment that affects cognition.

Additionally, in 2000, we commissioned a report from the National Research Council (NRC) about intellectual disability and determining eligibility for social security benefits, published in 2002.¹³ The primary focus of the report was people who have intellectual disability in what was called the "mild" range in the DSM-IV-TR, which means having IQ scores from 50-55 to approximately 70. In its report, the NRC concluded that for purposes of assessing impairment in people with intellectual disability, full scale IQ scores are generally better representations of general intelligence than are part scores because they combine a person's various skills and abilities to better reflect overall cognitive functioning. The NRC further noted that "[t]he intelligence test total score is also the single overall fairest predictor [of general intelligence] for individuals of differing ages, genders, races, and ethnic backgrounds. . . ."

Despite this recommendation, the NRC noted that in some instances when a person obtains a full scale IQ score from 71 through 75, it can be appropriate to use certain part scores (verbal or performance IQ scores) that are 70 or below to establish that the person has significant limitations in general intellectual functioning. We largely

¹³ National Research Council: Mental Retardation: Determining Eligibility for Social Security Benefits, National Academy Press, Washington, D.C. (2002) (available at: <http://www.nap.edu/catalog/10295/mental-retardation-determining-eligibility-for-social-security-benefits>).

adopted this recommendation for final listings 12.05B and 112.05B. We may find that a person's impairment satisfies the criteria in final 12.05B1 and 112.05B1 if the person has either: a full scale IQ score of 70 or below, or a full scale IQ score of 71-75 accompanied by either a verbal or performance IQ score of 70 or below.

Comment: Some commenters recommended that we provide guidance to adjudicators about how to consider the "standard error of measurement" and other similar aspects of IQ testing in this regulation. Several commenters recommended that we "give claimants the benefit of the doubt and include those individuals whose IQ scores place them within the standard error of measurement on standardized tests."

Response: We partially adopted the recommendations. The medical community recognizes measurement error for IQ scores (for example, the standard error of measurement). Test publishers often provide a range of scores around a person's obtained score that may also accurately represent a person's intellectual functioning. Similarly, as discussed above, one of the NRC's recommendations was to consider a range of full scale IQ scores from 71-75 in some instances.

In these final rules, we addressed these aspects of IQ testing by largely adopting the NRC recommendation. We added an alternative option for establishing that a person has significantly subaverage general intellectual functioning in final 12.05B1 and 112.05B1, as described in the response to the previous comment. This alternative enables some people with significantly subaverage general intellectual functioning and full scale

IQ scores that fall within a range of 71-75 to satisfy the IQ score requirement in final listings 12.05 and 112.05. Additionally, we expect to provide formal and accessible guidance to adjudicators about intelligence testing and final listings 12.05 and 112.05.

Comment: A commenter recommended that we use IQ scores from the 2008 Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV), General Ability Index (GAI) rather than the WAIS-IV full scale IQ score. The commenter asserted that the full scale IQ score can be artificially inflated in the newer Wechsler scale test editions, relative to older Wechsler tests. The commenter said that the fourth edition gives higher weights to subtests within the Working Memory Index (WMI) and Processing Speed Index (PSI). The commenter explained that because of the highly concrete nature of their tasks, the WMI and PSI scores can be relatively higher among intellectually disabled claimants and thus do not reflect deeper learning potential or problem-solving ability. The commenter believes that the GAI is a better summary measure of working memory and processing speed in the calculation of overall intelligence because it does not include WMI and PSI subtests.

Response: We did not adopt the comment. The restructuring of the WAIS and the resulting changes in scoring have raised questions for many people regarding the use of the full scale IQ score and the GAI. We appreciate the commenter's observations about differences between the two scores. However, the full scale IQ score contains more subtests (10) than the GAI (6), and therefore the full scale IQ score has higher and more stable reliability and validity coefficients. Furthermore, the four subtests used for

the WMI and PSI were a part of the full scale IQ score calculations in the earlier editions of the WAIS and continue to be included in the full scale IQ score calculation in the WAIS-IV. For these reasons, we do not agree with the recommendation to encourage adjudicators to use the GAI rather than the full scale IQ score as a summary measure of intelligence for listing 12.05.

Comment: Some commenters recommended that we add a provision to listings 12.05D and 112.05D to indicate that a person’s impairment will satisfy the listing requirements if the impairment results in “extreme” limitation of one of the functional criteria categories.

Response: We adopted the comment. As explained earlier in this preamble, the final rules reorganize listings 12.05 and 112.05. Final listings 12.05B and 112.05B include the provision that the commenters recommended.

Listings 12.09 and 112.09–Removed

Comment: Several commenters objected to the proposal to remove prior listing 12.09, substance addiction disorders from our rules. They provided various reasons in support of their position. For example, the spokesperson for an organization asked that we retain the listing to be consistent with the DSM-IV-TR and then-proposed DSM-5, because those publications have a category of impairment for “Addiction and Related Disorders.” As another example, some commenters acknowledged that although

substance use disorders alone are not grounds for disability in the current regulations, other government agencies, such as the U.S. Department of Health and Human Services, have documented the impact that these disorders have on the health and functioning of disabled people. As a third example, a commenter stated that substance abuse is one of the behavior disorders that can seriously affect functional capacity. That commenter also noted that a large percentage of cases requiring medical expert testimony related to mental disorders involve substance abuse issues.

Response: Although we appreciate the issues raised by the commenters, we did not adopt the recommendation to keep prior listing 12.09. Our current policy regarding how we evaluate claims involving substance use disorders comes from sections 223(d)(2)(C) and 1614(a)(3)(J) of the Act, which state that, “[a]n individual shall not be considered to be disabled . . . if alcoholism or drug addiction would . . . be a contributing factor material to the Commissioner’s determination that the individual is disabled.”¹⁴ Under this provision of the Act, we cannot find that a person is disabled based on his or her substance use disorder alone. Furthermore, if a claimant’s substance use is a medically determinable impairment and is material to a finding that the claimant is disabled, then we must find that the claimant is not disabled. (See our response to the prior comment that requested that we more clearly define the criteria and guidelines for determining the nature and effects of substance use on a person’s functional capacity for more information about our guidance on how we assess of the impact of substance use disorders.)

¹⁴ 42 U.S.C. §§ 432(d)(2)(C), 1382c(a)(3)(J).

These final rules remove prior listing 12.09 because we cannot use listing 12.09 alone to meet our definition of disability. In addition, listing 12.09 is a reference listing, which means that it only refers to medical criteria in other listings. As we revise the listings, we are also trying to eliminate reference listings. Finally, listing 12.09 is redundant because we use other listings to evaluate the physical or mental effects of substance use (for example, liver damage, peripheral neuropathy, or dementia). For these reasons, we are removing the listing.

Listing 112.14–Developmental disorders in infants and toddlers

Comment: A commenter requested that we keep the name of prior listing 112.12, “emotional and developmental disorders” for listing 112.14 for infants and toddlers. The commenter agreed with our decision to have a listing encompassing the period of birth to age 3 because this age group is better viewed as a continuum rather than as two distinct age groups, but disagreed with our removing the words, “emotional and,” and naming the listing only, “Developmental Disorders.” The commenter explained that, because “many [mental health] disorders are apparent prior to age three . . . and are distinct from developmental disorders . . . , eliminating emotional disorders will delay determination of eligibility for certain children for years.”

Response: We did not adopt the comment. We appreciate that the inclusion of “emotional” in the name of prior listing 112.12 was an effective way to emphasize that

children, even in the first year of life, can manifest emotional disturbance—a condition that has been identified, described, and increasingly studied by various early childhood authorities in the past 25 years. However, the term, “developmental disorders,” in final listing 112.14 is sufficiently broad to encompass all of the myriad ways in which an infant or toddler can present delays or deficits in typical early childhood development, including emotional disturbance.

Comment: The spokesperson for an organization suggested that we replace the proposed name of listing 112.14 with “neurodevelopmental delay” for children birth to 3 years.

Response: We did not adopt the comment. We appreciate the basis for the recommendation of “neurodevelopmental delay” as the name for listing 112.14 because developmental problems in very young children are often attributable to known neurological factors. However, the DSM-5 uses a very similar term, “neurodevelopmental disorders,” as the overall diagnostic category comprising disorders usually diagnosed in infancy, childhood, and adolescence. As a result, we are adopting the term “neurodevelopmental disorders” as the new title for listings 12.11 and 112.11. To avoid confusion, we are keeping the titles of listings 112.11 and 112.14 as different as possible.

Comment: The spokesperson for an organization recommended that we consider including fetal alcohol spectrum disorders as a “potential listing” in proposed listing

112.14, developmental disorders of infants and toddlers.

Response: We did not adopt the comment. Each listing does not include separate listings within it. Final 112.00B11b cites examples of disorders that we evaluate under this listing. However, we make clear that the list of examples is not all-inclusive. Fetal alcohol spectrum disorders (FASD) are known to produce the kinds of delay or deficit in the development of age-appropriate skills involving motor planning and control, learning, relating and communicating, and self-regulating that we address in listing 112.14. As with any disorder, the effects and severity of FASD can be highly variable across individuals. If an infant or toddler manifests a medically determinable developmental disorder of the severity described in listing 112.14, we will find the child disabled.

Comment: Some commenters recommended that we use age-related percentiles rather than fractions to assess developmental disorders in younger children. The commenters remarked that proposed listing 112.14 provided for the use of non-standardized measures for assessing developmental disorders in younger children, and that such a practice is appropriate if well-developed measures with age-standardized scores are not available. However, the commenters found our determination of impairment severity based on performance that is “more than one-half, but not more than two-thirds of chronological age” problematic given that standards based on fractions of what would be expected for chronological age have different meanings for children of different ages. The commenters illustrated the concern with the observations that performance of half of expected age in a 4-month-old infant represents a delay of only 2

months, while half of expected age for a 4-year-old child is a much more severe delay.

Response: We did not adopt the comment for two reasons. First, proposed section 112.00I4 included the references to fractions that the commenters mention. However, proposed 112.00I4 restated our guidance about fractions from § 416.926a(e). Rather than repeat guidance that we provide elsewhere in our regulations, in these final rules, we removed those provisions from 112.00I. Instead, we refer users to §§ 416.925(b)(2)(ii) and 416.926a(e) to find that information. As a result, the final rules no longer include the language the commenter mentions.

However, § 416.926a(e) also uses language very similar to, “more than one-half, but not more than two-thirds of chronological age.” We have used these fractions, and other similar ones, to determine disability in children since we published updated childhood disability regulations in 1991 (56 FR 5559). We use the fractions as an approximation when we do not have standardized test results in the case record. Our adjudicators are now very familiar with using these fractions in our program, and they find that the fractions are an accurate alternative and helpful when the case record does not have standardized test results.

Second, with respect to the illustration involving a 4-year-old child, according to § 416.926a(e), we use a fraction to assess a child’s functioning only up to age 3, and only in the absence of standardized test results. Therefore, we do not use fractions to assess the functioning of 4-year-old children.

Comment: A commenter recommended that we not defer disability determination for pre-term infants until attainment of corrected chronological age of 6 months. The commenter observed that adjustment of chronological age to account for a period of gestational prematurity is an accepted practice until a chronological age of 2 years, after which such adjustments are often not made. The commenter states, “a problem in using corrected age is that it may delay services for children who need them most. It would thus be critical not to defer disability determination in these cases, as this could result in delay in services to children with severe neurodevelopmental disorders. . . . While it is clear that the proposed rule changes specify that adjudication ‘may’ be deferred, rather than required, it would be important to emphasize in the rule changes that deferral of determination of age-expected development not be the default rule.”

Response: We did not adopt the comment. We do not believe the final rule in 112.00I5 includes guidance that adjudicators could interpret as a “default” action. In 112.00I5a and b, we explain that we will defer determination until an infant is at least 6 months old (chronological or corrected chronological age) if the evidence is insufficient to make a determination. Similarly, adjudicators have the option to defer determination beyond a child’s attainment of 6 months, if the available evidence warrants deferral. However, 112.00I5c states that we will not defer the determination if we have sufficient evidence to support a determination that a child is disabled under final listing 112.14 or any other listing.

We also appreciate that whether a premature infant's chronological age should be corrected to adjust for prematurity can be a significant factor in decisions regarding the provision of intervention services. However, in determining whether the same infant meets our statutory definition of disability, the sole basis for our determination is how the infant's development compares to established developmental milestones, based on chronological age ranges. It is necessary, then, that we correct chronological age to adjust for prematurity in order to make a determination that is fair to the infant.

Comment: A commenter recommended that we not defer disability determination for children born at extreme risk for ongoing developmental problems. This commenter said that "it is unclear that deferring determination of disability . . . is justifiable in cases of more extreme disability. There would seem to be little reason to defer assessment of a child born at extreme risk for ongoing developmental problems, such as those with perinatal brain insults, including hypoxic ischemic encephalopathy with severe deficits in early neurodevelopment, extreme prematurity with severe early neurologic impairments and perinatal strokes."

Response: We did not adopt this comment. We acknowledge that some government programs establish eligibility for services based on a child's "at risk" status. However, the Act and our regulations do not permit us to evaluate "risk" factors as the commenter describes.¹⁵ We consider only the effects of medically determinable impairments established by "medical evidence consisting of signs, symptoms, and

¹⁵ For more information about why we do not evaluate risk factors, see the preamble to the 1991 final rule with request for comments on determining disability for a child under age 18 (56 FR 5534, 5551).

laboratory findings” (see §§ 416.908 and 416.928). We do not require that the child’s treating providers identify a specific diagnosis to describe the child’s medical situation. However, there must be evidence of a medically determinable impairment that causes limitations in the child’s functioning. Under our rules, we consider certain medical situations, such as low birth weight in infants and failure to thrive in children, as medically determinable impairments. These impairments may cause developmental delays or physical effects that meet our definition of childhood disability (see, for example, listings 100.04 and 100.05).

With respect to infants with perinatal brain insults, such as hypoxic ischemic encephalopathy and perinatal strokes, we cannot know immediately following the insult what the outcome will be with respect to the infant’s developmental course. The provision for deferring adjudication until the infant is at least 6 months of age allows for the necessary documentation of the child’s developmental patterns and functioning over time. However, we do not defer determinations when we have sufficient evidence that a child’s impairment causes marked and severe functional limitations and can be expected to cause death, or has lasted or can be expected to last for a continuous period of not less than 12 months (see § 416.906).

Comment: The spokesperson for an organization stated that although the four paragraph B criteria for listing 112.14 reflect age-appropriate expectations and activities, reliably measuring the criteria can be difficult. The commenter recommended that we allow “temporary access to [supplemental security income (SSI)] benefits, pending repeat

and confirmatory testing of a child's disability severity to meet SSI standards.”

Response: This comment is outside the scope of this rulemaking, therefore we did not make any changes in these final rules in response to it. Although our program does not provide for “temporary access to SSI benefits,” we have rules providing for “presumptive disability” payments to claimants applying for SSI benefits. If the evidence available reflects a high degree of probability that the claimant meets our definition of disability, we may find initially that a claimant is “presumptively disabled.” This initial finding means that the claimant may receive benefits for up to 6 months before we make a formal determination about whether the claimant is disabled (see §§ 416.931-416.934).

Comment: A commenter advised us to identify the standardized developmental test instruments that the evidence should include so that adjudicators recognize “current validated screening modalities and do not accept antiquated assessment tools or approaches.”

Response: We did not adopt the comment. Although there are many developmental assessment instruments available from several publishers, we do not name individual tests in our regulations because we do not endorse proprietary (copyrighted) instruments. Additionally, tests are regularly developed or updated, and it would be impractical to attempt to maintain a current list of instruments in a regulation.

Summary of revisions we made in the final rules

As we described in our responses to the public comments, we are making changes to some of the proposals in the NPRM because of public comments we received. Although we explain all of those changes in detail later in this preamble, we summarized some of the more significant changes here. These changes include:

- Updating the titles of most of the listings;
- Keeping the structure of the “paragraph A” criteria from our prior rules in all of the listings (except for 12.05 and 112.05), and updating the paragraph A criteria;
- Renaming the titles of paragraph B1 (understand, remember, or apply information) and B3 (concentrate, persist, or maintain pace) to be linked by “or” rather than “and”;
- Removing all references to using standardized test scores for rating degrees of functional limitations for adults (except for listing 12.05);
- Indicating that the greatest degree of limitation in any part of a paragraph B1, B3, or B4 area of mental

functioning will be the degree of limitation for that whole area of functioning;

- Retaining the 5-point rating scale that we used in our prior rules for rating degrees of functional limitations in adults;

- Reorganizing the listing criteria in listings 12.05 and 112.05, intellectual disorder, to reflect the three diagnostic criteria for intellectual disability; and

- Creating new listings, 12.15 and 112.15, trauma- and stressor-related disorders, to reflect the updates in medical understanding reflected in the DSM-5.

Explanation of listing 12.05, intellectual disorder

Final listing 12.05 includes important changes that we explain here. We use listing 12.05 to evaluate claims involving intellectual disability. In the NPRM, we proposed mostly minor revisions to listing 12.05. However, some of the public comments that we received about this listing recommended that we substantively reorganize and change the listing criteria. The commenters criticized the listing structure that we proposed as “inconsistent, redundant and unnecessary.” One commenter

observed, “the severity of intellectual disability is written into the diagnosis itself.” The commenters recommended that we simplify the structure and the criteria for listing 12.05 so the listing would guide adjudicators through the process of identifying claimants who have intellectual disability.

In response to these comments, we revised the criteria for listing 12.05. We believe the revisions will continue to accurately and reliably identify claimants who have marked or extreme functional limitations due to intellectual disability. We also believe that the final listing will be clearer to adjudicators and the public. Furthermore, new listing 12.11 will identify claimants with cognitive impairments that result in marked or extreme functional limitations but do not satisfy the definition of intellectual disability. Our reasoning and explanation for those changes is below.

Intellectual disability

“Intellectual disability” is a diagnosis used by the medical community to identify and describe a certain type and degree of cognitive impairment. The American Psychiatric Association, the American Psychological Association, and the AAIDD are three leading experts within the medical community about what “intellectual disability” is. Those three organizations largely agree about what the three diagnostic criteria, or the three elements, are for intellectual disability. Those three elements, restated here, are: significant limitations in general intellectual functioning, significant deficits in adaptive functioning, and evidence that the disorder began during the developmental period.

Intellectual disability policies proposed in the NPRM

In the NPRM, we proposed to remove the capsule definitions in all of the prior mental disorders listings, including listing 12.05. Like prior listing 12.05, the version of listing 12.05 proposed in the NPRM had four paragraphs, paragraphs A-D. A person's impairment would meet the listing if it satisfied the criteria in any one of the four paragraphs. As in prior listing 12.05, we proposed to use paragraph A to evaluate claimants whose cognitive impairment prevented them from taking a standardized intelligence test. We proposed to use paragraph B to evaluate claimants who had an IQ score of 59 or lower. We proposed to use paragraph C to evaluate claimants with an IQ score of 60 through 70 with another severe physical or mental impairment. We proposed to use paragraph D to evaluate claimants with an IQ score of 60 through 70 and marked degree of limitation in two of the four proposed areas of mental functioning that were typically included in "paragraph B" of the other mental disorders listings.

Although proposed listing 12.05 did not have a capsule definition like prior listing 12.05, the proposed listing required that a claimant have significantly subaverage general intellectual functioning, deficits in adaptive functioning, and evidence that the disorder initially manifested during the developmental period. The beginning of each lettered paragraph required that a claimant have intellectual disability "as defined in [proposed] 12.00B4" before stating the listing criteria specific to that paragraph. Proposed section 12.00B4a stated, "This disorder is defined by significantly subaverage general intellectual

functioning with significant deficits in adaptive functioning initially manifested before age 22.” Therefore, the version of listing 12.05 proposed in the NPRM was similar to prior listing 12.05, but it did not include a capsule definition, and it moved the three elements of the medical definition of intellectual disability into the introductory text.

Intellectual disability in final listing 12.05

However, the public comments that we received in response to the NPRM, as described above, made clear to us that the reorganized criteria that we proposed in the NPRM was still insufficient. In response to these comments, we reorganized the listing criteria in these final rules to reflect the three elements of the medical definition of intellectual disability.

Final listing 12.05 does not include a capsule definition. The listing has only two paragraphs, and we will allow a claim under the listing when the criteria in either paragraph are satisfied. Each paragraph contains the three elements of the medical definition of intellectual disability. Therefore, the listing is now very similar to the DSM-5 and AAIDD definitions for intellectual disability.

We will use final listing 12.05A to evaluate the claims of people whose cognitive impairment prevent them from taking a standardized intelligence test that would measure their general intellectual functioning. Listing 12.05A has three subparagraphs; there is one subparagraph for each element of the medical definition of intellectual disability.

The first subparagraph requires that a claimant lack the cognitive ability to participate in standardized testing of intellectual functioning. Stated differently, if a claimant is not able to take an IQ test, this is sufficient evidence that the claimant has “significantly subaverage general intellectual functioning” as required by the listing.

The second subparagraph requires that a claimant be dependent on others to care for basic personal needs. If a claimant relies on others for such basic tasks, this is sufficient evidence that a claimant has “significant deficits in adaptive functioning” as required by the listing.

The last subparagraph requires evidence that demonstrates or supports the conclusion that the disorder began prior to age 22. For our program purposes, we use age 22 as the benchmark to establish that the disorder began during the developmental period.¹⁶ If a claimant’s impairment satisfies the requirements in all three subparagraphs, we will find that the claimant’s impairment meets the criteria for listing 12.05A.

We will use final listing 12.05B to evaluate the claims of people who are able to take a standardized intelligence test. Like final listing 12.05A, final listing 12.05B has three subparagraphs; there is one subparagraph for each element of the medical definition

¹⁶ Our use of age 22 in our program has a basis in clinical practice. Historically, the American Psychological Association used age 22 to identify people with “intellectual disability” (Jacobson, John W., and James A. Mulick, eds., Manual of Diagnosis and Professional Practice in Mental Retardation, American Psychological Association, Washington, D.C. (1996)) Today, in the disability insurance program, we use age 22 to identify claimants who may be eligible for benefits on the earnings record of an insured person who is entitled to old-age or disability benefits or who has died (20 CFR 404.350(a)). For these reasons, we continue to use age 22 as the benchmark to establish that intellectual disability began during the developmental period.

of intellectual disability. The first subparagraph requires a claimant to have obtained either: a full scale IQ score of 70 or below, or a full scale IQ score of 71 through 75 accompanied by a verbal or performance IQ score of 70 or below. Stated differently, if a claimant's IQ scores meet either of these requirements, there is sufficient evidence that the claimant has "significantly subaverage general intellectual functioning" as required by the listing.

The second sub-paragraph requires that a claimant have extreme limitation of one, or marked limitation of two, of the four "paragraph B" areas of mental functioning (see 12.00E1, 2, 3, and 4). We use the same paragraph B criteria and severity ratings to evaluate a person's current adaptive functioning under listing 12.05 that we use to evaluate the functioning of a person using all of the other mental disorders listings in this body system. We use the paragraph B areas of mental functioning to evaluate a person's abilities to acquire and use conceptual, social, and practical skills.¹⁷ If a claimant has "extreme" limitation of one, or "marked" limitation of two, of the paragraph B criteria, this is sufficient evidence that a claimant has "significant deficits in adaptive functioning" as required by the listing.

The last sub-paragraph requires evidence that demonstrates or supports the conclusion that the disorder began prior to age 22. If a claimant's impairment satisfies

¹⁷ In its definitions of "intellectual disability" and discussions of adaptive behavior, the AAIDD refers to "conceptual, social, and practical skills" (Intellectual Disability: Definition, Classification, and Systems of Supports, 11th Edition, Chapter 5); the DSM-5 refers to "conceptual, social, and practical domains." (American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, 33-41)

the requirements in all three sub-paragraphs, we will find that the claimant's impairment meets the criteria for listing 12.05B.

The revised criteria in final listings 12.05A and B respond to the public comments that suggested that we simplify the listing structure by guiding adjudicators through the process of identifying claimants who have intellectual disability. Importantly, and as noted above, the mental disorders listings are function-driven, not diagnosis-driven, and the final listing criteria reflect this approach.

The role of listing 12.11

Although prior listing 12.05 included a capsule definition that was very similar to the medical definition of intellectual disability, the capsule definition did not indicate how significant the claimant's subaverage general intellectual functioning and deficits in adaptive functioning had to be. For example, other mental impairments, such as specific learning disability and borderline intellectual functioning, can involve subaverage general intellectual functioning and deficits in adaptive functioning, as well as evidence that the disorder initially manifested during the developmental period. However, claimants with impairments such as specific learning disability and borderline intellectual functioning do not have the same nature or degree of subaverage intellectual functioning and deficits in adaptive functioning as people with intellectual disability.

The reorganization of listing 12.05 will mean that cognitive impairments other

than intellectual disability will not meet the listing criteria for 12.05. We will use final listing 12.11, neurodevelopmental disorders, to evaluate these impairments. Section 12.00B9, which is the section of the introductory text that describes this listing, explains that we evaluate impairments such as specific learning disorder and borderline intellectual functioning under listing 12.11. This listing furthers our goal to identify claimants with disabling impairments accurately, reliably, and as early in the sequential evaluation process as possible.

Other significant revisions relating to listing 12.05

We made three other changes relating to listing 12.05 in response to public comments we received. First, as explained earlier in the preamble, we changed the title of the listing to “intellectual disorder.” Second, we changed our rules about standardized intelligence test results. Under the final rules, we use a full scale IQ score, or a combination of a full scale IQ score with either a verbal or performance IQ score, to determine if a claimant’s disorder satisfies the criteria in listing 12.05. Commenters suggested that we make these two changes, and we agreed with them.

Third, the nature and extent of the comments we received about listing 12.05 indicated that we needed to provide more guidance to adjudicators at the regulatory level about how to apply the listing criteria. Therefore, we added final 12.00H to the introductory text to consolidate and clarify the guidance for listing 12.05.

Final 12.00—Introductory Text to the Adult Mental Disorders Listings

The following is a description of the content and changes in each section of Part A, the adult mental disorders listings.

Final 12.00A: How are the listings for mental disorders arranged, and what do they require?

Final 12.00A names the mental disorders listings, and it describes how we organized the listing criteria into either two or three lettered paragraphs for all listings (except 12.05). We explain that each lettered paragraph contains a specific type of listing criteria, and we state what criteria must be satisfied in order for us to find that a person's impairment meets the listing. This section also explains how we organized the criteria in final listing 12.05 differently from the other listings.

In these final rules, we changed the title of final 12.00A from, "What are the listings, and what do they require?" to, "How are the listings for mental disorders arranged, and what do they require?" for clarity.

Final 12.00A2a reflects a change we made to the paragraph A criteria in these final rules. In the NPRM, we proposed that the paragraph A criteria would require a claimant to show that he or she had a medically determinable mental disorder in the listing category (for all listings except 12.05). However, these final rules keep paragraph

A criteria in each listing that are similar to the criteria in our prior rules and include a list of medical criteria that must be present in a person's medical record. We made this change in response to a public comment raising concern that the paragraph A criteria in our prior rules served an important function by providing a basis for comparing and assessing the severity of different mental disorders. The commenter urged us to reconsider "elimination" of the paragraph A criteria. We summarized the comment and explained our reasons for adopting it earlier in this preamble. As a result, final 12.00A2 explains that paragraph A of each listing (except 12.05) includes the medical criteria that must be present in a person's medical evidence.

Final 12.00A2 also includes a change we made to the paragraph C criteria in these final rules. In the NPRM, we proposed to include paragraph C criteria in all listings (except 12.05). However, these final rules keep paragraph C criteria only in the final listings that correspond closely to the prior listings that included paragraph C criteria (final listings 12.02, 12.03, 12.04, 12.06, and 12.15). We made this change because our medical and psychological experts, and our adjudicative experience, indicate to us that the unique medical situation that we identify with the paragraph C criteria typically does not apply to the other disorders we evaluate under the remaining listings. As a result, final 12.00A2c explains that paragraph C of listings 12.02, 12.03, 12.04, 12.06, and 12.15 provides the criteria we use to evaluate "serious and persistent mental disorders."

Final 12.00A3 reflects the way that these final rules revise the listing criteria for 12.05. We explain the changes to listing 12.05 and our reasons for making them earlier

in this preamble.

Final 12.00B: Which mental disorders do we evaluate under each listing category?

In these final rules, we changed the title of final 12.00B from, “How do we describe the mental disorders listing categories?” to, “Which mental disorders do we evaluate under each listing category?” for clarity. We removed the introductory paragraph in proposed 12.00B because the information was only descriptive or included elsewhere in the introductory text.

Final 12.00B contains numbered sections that correspond to each listing. The numbered sections provide information about the types of mental disorders we evaluate under each listing. For example, final 12.00B1 corresponds to listing 12.02 and provides information about neurocognitive disorders.

In final 12.00B, each numbered section contains either two or three lettered paragraphs. The first lettered paragraph provides a description of the mental disorders included in each listing category, followed by examples of symptoms and signs commonly associated with those disorders. The second paragraph provides examples of disorders we evaluate under each listing. We updated these paragraphs with revised medical terms from the DSM-5. In sections that have a third paragraph, this paragraph lists examples of mental disorders that we do not evaluate under each listing.

In final 12.00B4, which discusses listing 12.05, intellectual disorder, we removed proposed paragraphs 12.00B4c and B4d. These paragraphs discussed our requirements for documentation and standardized intelligence testing. We included this guidance in final 12.00H, a new section that provides additional information about how to apply listing 12.05. We also removed proposed 12.00B4e from these final rules. That paragraph explained proposed listing 12.05C, and these final rules do not include a listing 12.05C, as we explained earlier in this preamble.

We added final 12.00B11 to provide information about the types of mental disorders we evaluate under new listing 12.15, trauma- and stressor-related disorders.

Final 12.00C (Proposed 12.00G): What evidence do we need to evaluate your mental disorder?

Final 12.00C describes the types of evidence that we need to evaluate a person's mental disorder. In these final rules, we moved this discussion from proposed 12.00G to final 12.00C to present the information earlier in the introductory text. This reorganization allows us to explain the evidence we need (in final 12.00C) and how we consider the supports a person receives (in final 12.00D) before we explain how we evaluate a person's mental disorder using the paragraph B criteria (in final 12.00E and final 12.00F).

In final 12.00C2, we discuss and list examples of evidence from medical sources.

We removed psychosocial supports or highly structured settings from the list (proposed 12.00C2k) because they are not examples of medical evidence, and because final 12.00D is devoted to those topics. We added psychiatric and psychological rating scales and measures of adaptive functioning to the list, and we removed the brief discussion about these topics from proposed 12.00G5.

In final 12.00C3, we discuss non-medical sources of evidence, such as the claimant and people who are familiar with the claimant. We clarified that we will ask third parties for information about a claimant's impairments, but we must have the claimant's permission to do so. In response to public comments, we added social workers, shelter staff, and other community support and outreach workers to the list of examples of sources of evidence.

In final 12.00C5, we explain how longitudinal evidence can help us learn how a person functions over time, and how we evaluate impairments when there is no longitudinal evidence. We moved the discussion about how we evaluate exacerbations and remissions of mental disorders from proposed 12.00G6a to final 12.00F4 because final 12.00F provides information about how we evaluate a person's mental disorder, and the discussion of exacerbations and remissions of mental disorders is most appropriate in that section. In response to public comments, we added case managers, community support staff, and outreach workers as examples of non-medical sources of longitudinal evidence.

Final 12.00C5c is a new section that provides additional guidance about how we will evaluate a person's mental disorder when there is no longitudinal evidence. In partial response to public comments recommending that we recognize the unique circumstances of people who are experiencing homelessness, we included chronic homelessness as an example of a situation that may make it difficult to obtain longitudinal medical evidence.

In final 12.00C6, we added more information about how we use evidence of a person's functioning in unfamiliar or supportive situations, and we removed the paragraphs that discussed the effects of work-related stress.

Final 12.00D (Proposed 12.00F): How do we consider psychosocial supports, structured settings, living arrangements, and treatment?

Final 12.00D describes how we consider the effects of psychosocial supports, structured settings, living arrangements, and treatment on a person's functioning. In these final rules, we moved this discussion from proposed 12.00F to final 12.00D to present the information earlier in the introductory text.

In final 12.00D1, we explain how psychosocial supports and highly structured settings may help a person function. We added "living arrangements" and "assistance from your family or others" to this discussion for clarity. In response to public comments, we clarified that the list of examples of psychosocial supports and highly

structured settings includes only “some” examples of supports that a person “may” receive. We added this language to indicate that the list of supports does not include all of the possible supports that we consider. We simplified the list of examples of supports and settings by combining the examples that illustrate similar situations. In response to public comments, we added comprehensive “24/7” mental health services, also known as “wrap-around” services, to the list of examples. Also in response to public comments, we added an example of receiving assistance from mental health workers who help the person meet physical needs and who may assist in dealings with government or social services.

We added a new section, final 12.00D2, to explain how we consider different levels of support and structure in psychosocial rehabilitation programs. Based on our adjudicative experience, we realized that we needed to provide further guidance about how to evaluate the extent of a person’s participation and what that tells us about the effects of the person’s mental disorder and current functioning.

We added another new section, final 12.00D3, in response to public comments expressing concern about how we consider a person’s strengths and deficits in his or her daily functioning. Final 12.00D3 explains that we acknowledge that a person may demonstrate both strengths and deficits, and we will consider the complete picture of a person’s daily functioning when we evaluate whether that person is able to use his or her areas of mental functioning in a work setting.

Final 12.00E (Proposed 12.00C): What are the paragraph B criteria?

Final 12.00E defines and describes the four paragraph B criteria, which represent the areas of mental functioning a person uses in a work setting. Final 12.00E has four numbered paragraphs. There is one paragraph for each paragraph B criterion. For example, final 12.00E1 contains the definition and description for paragraph B criterion B1, understand, remember, or apply information.

In these final rules, we moved the discussion of the paragraph B criteria from proposed 12.00C to final 12.00E. We removed the introductory paragraph in proposed 12.00E because the information was only descriptive or included elsewhere in the introductory text.

We expanded the definitions of each paragraph B criterion, and we added more examples of how a person uses his or her areas of mental functioning in the workplace. We made these changes in response to public comments we received suggesting that we should be more specific about each of the areas of mental functioning in the context of a work setting. We discuss these public comments and our responses to them earlier in this preamble. In final 12.00E4 where we define and describe the paragraph B4 criterion, after we revised the definition and examples in response to the public comments, we changed the title of this criterion to include the word “adapt” to reflect the abilities and behaviors that we consider more accurately and completely. We also added a statement at the end of each paragraph clarifying that the examples illustrate the nature of the areas

of mental functioning, and we do not require documentation of all of the examples.

We changed the title of paragraph B1 from “understand, remember, and apply information” to “understand, remember, or apply information.” We changed the title of paragraph B3 from “concentrate, persist, and maintain pace” to “concentrate, persist, or maintain pace.” We made this change to link the parts in the title with the word “or” rather than “and” in response to several public comments that we received. The commenters were concerned that people could misinterpret the titles as proposed in the NPRM as a change from our prior policy that would set a higher standard for a person’s mental disorder to satisfy those criteria. We adopted the comment, and we explain our reasons earlier in this preamble.

Final 12.00F (Proposed 12.00D): How do we use the paragraph B criteria to evaluate your mental disorder?

Final 12.00F explains how we use the paragraph B criteria and a rating scale to evaluate a person’s mental disorder. In these final rules, we moved this guidance from proposed 12.00D to final 12.00F. We also made several significant changes to this section because of public comments we received. We explain these changes below.

In final 12.00F1, we introduce the concept of using a rating scale. A public commenter requested that we explain how adjudicators assess limitations in cases where psychosocial supports and highly structured settings are present. In partial response to

this comment, we added an explanation that we will consider the nature of the difficulty the person would have, whether the person could function without extra help, and whether the person would require special conditions with regard to activities or other people.

In final 12.00F2, we explain that we use a five-point rating scale consisting of none, mild, moderate, marked, and extreme to assess the degrees of limitation an adult has using his or her areas of mental functioning. Several public commenters objected to our proposal in the NPRM to use only the terms “marked” and “extreme” to assess an adult’s limitations. The commenters advised us that continuing our use of the 5-point rating scale from our prior rules would help “anchor” the standards of “marked” and extreme.” We adopted the suggestion to keep our five-point rating scale in these final rules. We discuss these public comments and our responses earlier in this preamble.

Also in final 12.00F2, we provide definitions for each of the five points of the scale. The definitions are consistent with how our adjudicators have understood and used the rating scale since we first introduced it in 1985. As we explain earlier in this preamble, we provide these definitions to respond, in part, to the significant public comments we received that objected to the descriptions of “marked” and “extreme” that we proposed in the NPRM. In the NPRM, we proposed to describe “marked” and “extreme” as equivalent to scores that are a certain number of standard deviations below the mean on individually administered standardized tests. However, in light of the objections raised in the majority of the public comments, we did not adopt those

definitions in these final rules.

Also in response to those public comments, we did not make final most of the rules we proposed in 12.00D4 about how we would consider test results when we assessed a person's functional limitations. In these final rules, we moved and changed the guidance about professional interpretation of test results to final 12.00H2d because final 12.00H provides additional information about the criteria in listing 12.05, and listing 12.05B is the only listing that requires standardized test results.

In final 12.00F3, we discuss how we rate the severity of limitations resulting from a mental disorder. In final 12.00F3a, we explain that when rating a person's impairment-related limitations, we use all relevant evidence in the case record. We received public comments raising concern that adjudicators might misconstrue a clinician's use of the term "mild" or "moderate" in diagnosing the stage of a person's mental disorder as a description of the person's level of functioning with respect to the paragraph B criteria. In response to this concern, we added language to final 12.00F3a explaining that although the medical evidence may include descriptors regarding the diagnostic stage or level of a disorder, such as "mild" or "moderate," these terms will not always be the same as the degree of limitation in a paragraph B area of mental functioning.

Final 12.00F3b and F3c are new sections that explain how we consider evidence about and assess a person's ability to use his or her areas of mental functioning in daily functioning and in work settings. Final 12.00F3d and F3e incorporate the proposed

sections 12.00D1c and D1d, which provide additional guidance concerning overall effect of limitations and effects of support, supervision, and structure on functioning.

We added a new section, final 12.00F3f, in response to public comments asking that we clearly explain how we will rate the limitation of the individual parts of paragraphs B1, B3 and B4. As requested, we explain that the greatest degree of limitation in any part of a paragraph B1, B3 or B4 area of mental functioning will be the degree of limitation for that whole area of functioning.

Final 12.00F4 incorporates proposed section 12.00G6 and describes how we evaluate mental disorders involving exacerbations and remissions. In response to a public comment, we added an explanation that we will consider whether a person can use the affected area of mental functioning on a regular and continuing basis (8 hours a day, 5 days a week, or an equivalent work schedule).

Final 12.00G (Proposed 12.00E): What are the paragraph C criteria, and how do we use them to evaluate your mental disorder?

Final 12.00G defines and describes the paragraph C criteria, which are an alternative to the paragraph B criteria under listings 12.02, 12.03, 12.04, 12.06, and 12.15. In these final rules, we moved the discussion of the paragraph C criteria from proposed 12.00E to final 12.00G. We retained the two-year documentation requirement from our prior rules in these final rules to ensure that the disorders evaluated using these

criteria are “serious and persistent.”

In final 12.00G2b, we provide more information about the requirement that continuing treatment, psychosocial supports, or structured settings diminish the symptoms and signs of a person’s mental disorder. We clarify that a claimant must rely, on an ongoing basis, upon medical treatment, mental health therapy, psychosocial supports, or a highly structured setting, to diminish the symptoms and signs of his or her mental disorder. As we discuss earlier in this preamble, a public commenter raised concern that many people with mental disorders lack awareness about their mental disorders and therefore refuse treatment. To respond to this comment, we added language in final 12.00G2b to explain how we will consider a claimant’s inconsistent treatment or lack of compliance when we determine whether the claimant relies upon “ongoing” medical treatment as this section requires.

Final 12.00H: How do we document and evaluate intellectual disorder under 12.05?

Final 12.00H is a new section that brings together the rules pertaining to listing 12.05, intellectual disorder. This section devoted to listing 12.05 is necessary because of the differences between this listing and all other mental disorders listings, and the several clarifications provided in these final rules about adjudicating claims under listing 12.05. Final 12.00H includes information and guidance about establishing significantly subaverage general intellectual functioning, establishing significant deficits in adaptive functioning, and establishing that the disorder began before age 22. We include

subsections that discuss the evidence we consider, standardized tests of intelligence, adaptive functioning, and our consideration of common everyday activities and work activity.

Final 12.00H2a describes how we establish significantly subaverage general intellectual functioning, which is one of the criteria for listing 12.05. This section explains that we identify significantly subaverage general intellectual functioning by an IQ score(s). Final 12.00H2b and H2c are new sections that describe our psychometric standards. We added these sections in response to a public comment noting that our prior rules had information on these important topics, but the proposed rules did not.

We moved and changed the guidance about how we will consider IQ test scores from proposed 12.00B4d and 12.00D4 to final 12.00H2d. We revised the policies in response to several public comments raising concern that the proposed rules about interpreting test results gave too much discretion to adjudicators who may not have the expertise of the test administrators. In response to these comments, final 12.00H2d indicates that only qualified specialists, Federal and State agency medical and psychological consultants, and other contracted medical and psychological experts may conclude that an obtained IQ score is not an accurate reflection of a claimant's general intellectual functioning. We explain our reasons for making this change in detail earlier in this preamble.

Final 12.00I (Proposed 12.00H): How do we evaluate substance use disorders?

This section explains how we evaluate mental disorders that do not meet one of the mental disorders listings. In these final rules, we moved this information from proposed 12.00H to final 12.00I to accommodate adding new a section, final 12.00H earlier in the introductory text. Although we received several public comments requesting changes regarding this section of the rules, we were unable to make those changes for reasons we explain earlier in this preamble. We did not make any substantive changes to this section.

Final 12.00J (Proposed 12.00I): How do we evaluate mental disorders that do not meet one of the mental disorders listings?

This section explains how we evaluate mental disorders that do not meet one of the mental disorders listings. This section also explains what rules we use when we decide whether a person receiving benefits continues to be disabled. In these final rules, we moved this information from proposed 12.00I to final 12.00J to accommodate adding final 12.00H earlier in the introductory text. We did not make any substantive changes to this section.

12.01 Category of Impairments, Mental Disorders

The final rules revise all of the mental disorders listings. We made many of the revisions in response to public comments on the NPRM. To avoid repeating the same

information multiple times, the list below summarizes the changes that apply to many or all of the listings:

- The final rules update the titles of listings 12.02, 12.03, 12.04, 12.06, 12.07, 12.08, 12.11, and 12.15 to reflect the terms the APA uses to describe the categories of mental disorders in the DSM-5.

- All final listings (except for 12.05 and 112.05) include “paragraph A criteria” that are similar to our prior rules. We kept the paragraph A criteria in the listings in response to a public comment on the NPRM that identified the benefits of having the criteria. The paragraph A criteria in the final listings reflect the diagnostic criteria of disorders in the DSM-5. Although a claimant must have a medically determinable mental impairment, the claimant does not have to have a diagnosis for his or her mental impairment to satisfy the listing criteria. The medical evidence must demonstrate the required paragraph A criteria are present for us to find that the impairment meets the listing.

- We changed the title of the paragraph B1 criteria to

"understand, remember, or apply information," and the title of the paragraph B3 criteria to "concentrate, persist, or maintain pace." The titles are linked by "or" rather than "and" in response to public comments on the NPRM, and to clarify our rules about how we rate a person's degree of functional limitation.

- We changed the title of paragraph B4 to "adapt or manage oneself" in partial response to public comments on the NPRM.

- The final rules revise the paragraph C criteria in listings 12.02, 12.03, 12.04, 12.06, and 12.15. The paragraph C criteria state that a person must have a medically documented history of the existence of his or her disorder over a period of at least 2 years. This requirement is consistent with our prior rules.

- Final listings 12.07, 12.08, 12.10, 12.11 and 12.13 do not include paragraph C criteria. We made this change because our medical and psychological experts, and our program experience, indicate that the unique medical situation we identify with the paragraph C criteria

typically does not apply to the disorders we evaluate under these listings.

In addition to these changes, we also made changes to individual listings. We describe those changes in the following sections.

12.05 Intellectual disorder

Final listing 12.05 includes important revisions that we made in response to public comments. The name of the listing is now intellectual disorder, and we organized the criteria in the listing to reflect the three elements of the medical definition of intellectual disability. We explain these changes and our reasons for making them earlier in this preamble.

12.15 Trauma- and stressor-related disorders

Final listing 12.15 is a new listing we will use to evaluate trauma- and stressor-related disorders such as posttraumatic stress disorder. Prior versions of the DSM, such as the DSM-IV-TR, included trauma- and stressor-related disorders as a type of anxiety disorder. Under our prior rules, we evaluated trauma- and stressor-related disorders under prior listing 12.06, anxiety-related disorders. However, the DSM-5 created a separate diagnostic category for trauma- and stressor-related disorders. As a result, we created new listing 12.15 to evaluate these types of impairments.

The paragraph A criteria in final listing 12.15 reflect diagnostic criteria of posttraumatic stress disorder, which is a type of trauma- and stressor-related disorder included in the DSM-5. Final listing 12.15 includes paragraph C criteria because prior listing 12.06 included the criteria, and because our medical and psychological experts advised us that the unique medical situation that we identify with the paragraph C criteria often applies to trauma- and stressor-related disorders.

The following is a detailed description of the changes in pertinent sections of Part B, the Childhood Mental Disorders Listings.

112.00 Mental Disorders

We made a number of changes throughout 112.00 to make the final childhood mental disorders listings consistent with the final adult listings. In some cases, the revisions are not substantive. In others, our reasons for the changes are the same as our reasons for changing the adult rules, and we explain them earlier in this preamble. We also made minor changes in 112.00, either to clarify or enhance our discussion of the rules for children. In the following sections, we explain the substantive changes to 112.00 that were not applicable to our explanation of the changes to the adult rules.

Final 112.00F (Proposed 112.00D): How do we use the paragraph B criteria to evaluate mental disorders in children?

Final 112.00F explains how we use the paragraph B criteria to evaluate a child’s mental disorder. In final 112.00F2, we explain that a child’s mental disorder must result in extreme limitation of one, or marked limitation of two, paragraph B criteria. We provide citations to §§ 416.925(b)(2)(ii) and 416.926a(e) for the definitions of the terms “marked” and “extreme” for child claimants. Although we suggested definitions for marked and extreme in proposed 112.00D2 and D3, we did not make those definitions final. The definitions we proposed for children were similar to the definitions that we proposed for adults. We did not make final the proposed definitions in the adult listings for the reasons we explained earlier in the preamble. Furthermore, our childhood policy regulations already include definitions for the terms marked and extreme. For these reasons, we removed definitions of marked and extreme from 112.00F2, and we include a citation to the definitions of those terms in our regulations.

Final 112.00I: What additional considerations do we use to evaluate developmental disorders of infants and toddlers?

Final 112.00I explains how we use listing 112.14 to evaluate developmental disorders of infants and toddlers from birth to age three. In these final rules, we made changes to this section and reorganized how we present the information to avoid repeating guidance found elsewhere in the introductory text.

In final 112.00I2, we discuss how we calculate a child’s age and how we assess a child’s level of development. We expanded our discussion from proposed 112.00I2c to

include guidance about when we will use a child's corrected chronological age, and how we use developmental assessments. We moved the description of the listing category from proposed 112.00I2a and I2b to 112.00B, where we describe all other listing categories.

In final 112.00I3, we added additional information about the types of evidence that we typically receive for infants and toddlers from birth to age three. We removed proposed sections 112.00I4 and I5 that provided information about how we use the paragraph B criteria to evaluate a developmental disorder and how we consider supports when we evaluate a child's functioning. These sections duplicated the revised guidance we provide in final 112.00F and G, and we do not need to repeat them. We renumbered the guidelines about deferring determinations from proposed 112.00I6 to final 112.00I5.

The following is a detailed description of the changes in §§ 404.1520a and 416.920a.

Sections 404.1520a and 416.920a: Evaluation of Mental Impairments

Sections 404.1520a and 416.920a describe a special technique, known as the psychiatric review technique, which we use when we evaluate the severity of mental impairments for adults, and for persons under age 18 when we use Part A of the listings. Although we proposed in the NPRM to remove these two sections, the final rules keep these sections because of public comments we received, and for the reasons we explained

earlier in the preamble. Therefore, we are not making final the changes proposed in the NPRM to sections 404.941, 404.1503, 404.1615, 416.903, 416.934, 416.1015, and 416.1441. We are making conforming changes to sections 404.1520a and 416.920a to be consistent with the final rules. In paragraphs (c) and (d) of each section, we removed the references to the four paragraph B criteria from our prior rules and replaced them with the four updated paragraph B criteria from these final rules. We also removed the references to the unique rating scale that only applied to paragraph B4 under our prior rules, “episodes of decompensation,” because it is no longer necessary under the final rules.

What is our authority to make rules and set procedures for determining whether a person is disabled under our statutory definition?

Under the Act, we have authority to make rules and regulations and to establish necessary and appropriate procedures to carry out such provisions.¹⁸

How long will these final rules be in effect?

These final rules will remain in effect for 5 years after the date they become effective, unless we extend them, or revise and issue them again. We will continue to monitor these rules to ensure that they continue to meet program purposes, and may revise them before the end of the 5-year period if warranted.

¹⁸ See sections 205(a), 702(a)(5), and 1631(d)(1) (42 U.S.C. 405(a), 902(a)(5), 1383(d)(1)).

REGULATORY PROCEDURES

Executive Order 12866, as Supplemented by Executive Order 13563

We consulted with the Office of Management and Budget (OMB) and determined that these final rules meet the criteria for a significant regulatory action under Executive Order 12866, as supplemented by Executive Order 13563. Therefore, OMB reviewed these final rules.

Regulatory Flexibility Act

We certify that these final rules will not have a significant economic impact on a substantial number of small entities because they affect individuals only. Therefore, the Regulatory Flexibility Act, as amended, does not require us to prepare a regulatory flexibility analysis.

Paperwork Reduction Act

These rules do not create any new or affect any existing collections and, therefore, do not require Office of Management and Budget approval under the Paperwork Reduction Act.

(Catalog of Federal Domestic Assistance Program Nos. 96.001, Social Security—Disability Insurance; 96.002, Social Security—Retirement Insurance; 96.004, Social

Security—Survivors Insurance; and 96.006, Supplemental Security Income)

List of Subjects

20 CFR Part 404

Administrative practice and procedure; Blind; Disability benefits; Old-age, Survivors, and Disability Insurance; Reporting and recordkeeping requirements; Social Security.

20 CFR Part 416

Administrative practice and procedure, Aged, Blind, Disability cash payments, Public assistance programs, Supplemental Security Income (SSI), Reporting and recordkeeping requirements.

Carolyn W. Colvin,
Acting Commissioner of Social Security.

For the reasons set out in the preamble, we are amending subpart P of part 404 and subpart I of part 416 of chapter III of title 20 of the Code of Federal Regulations as set forth below:

PART 404—FEDERAL OLD-AGE, SURVIVORS AND DISABILITY INSURANCE
(1950-)

Subpart P—Determining Disability and Blindness

1. The authority citation for subpart P of part 404 continues to read as follows:

Authority: Secs. 202, 205(a)-(b) and (d)-(h), 216(i), 221(a), (i), and (j), 222(c), 223, 225, and 702(a)(5) of the Social Security Act (42 U.S.C. 402, 405(a)-(b) and (d)-(h), 416(i), 421(a), (i), and (j), 422(c), 423, 425, and 902(a)(5)); sec. 211(b), Pub. L. 104-193, 110 Stat. 2105, 2189; sec. 202, Pub. L. 108-203, 118 Stat. 509 (42 U.S.C. 902 note).

2. Amend § 404.1520a by revising paragraphs (c)(3) and (4) and (d)(1) to read as follows:

§ 404.1520a Evaluation of mental impairments.

* * * * *

(c) * * *

(3) We have identified four broad functional areas in which we will rate the degree of your functional limitation: understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself. See 12.00E of the Listing of Impairments in appendix 1 to this subpart.

(4) When we rate your degree of limitation in these areas (understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself), we will use the following five-point scale: none, mild, moderate, marked, and extreme. The last point on the scale represents a degree of limitation that is incompatible with the ability to do any gainful activity.

(d) * * *

(1) If we rate the degrees of your limitation as “none” or “mild,” we will generally conclude that your impairment(s) is not severe, unless the evidence otherwise indicates that there is more than a minimal limitation in your ability to do basic work activities (see § 404.1521).

* * * * *

3. Amend appendix 1 to subpart P of part 404 as follows:

a. Revise item 13 of the introductory text before part A.

b. Revise section 12.00 of part A.

c. In Part B:

i. Revise section 112.00.

ii. Revise the first sentence of section 114.00D6e(ii).

iii. Remove section 114.00I and redesignate section 114.00J as section 114.00I.

iv. Revise 114.02 and 114.03.

v. Remove the semicolon and the word “or” after section 114.04C2 and add a period in their place.

vi. Remove section 114.04D.

vii. Remove the word “or” after section 114.05D.

viii. Remove section 114.05E.

ix. Revise 114.06.

x. Remove the word “or” after section 114.07B.

xi. Remove section 114.07C.

xii. Remove the word “or” after section 114.08K6.

xiii. Remove section 114.08L.

xiv. Remove the word “or” after section 114.09C2.

xv. Remove section 114.09D.

xvi. Revise 114.10.

The revisions read as follows:

Appendix 1 to Subpart P of Part 404--Listing of Impairments

* * * * *

13. Mental Disorders (12.00 and 112.00): January 17, 2022.

* * * * *

Part A

* * * * *

12.00 MENTAL DISORDERS

A. How are the listings for mental disorders arranged, and what do they require?

1. The listings for mental disorders are arranged in 11 categories: neurocognitive disorders (12.02); schizophrenia spectrum and other psychotic disorders (12.03); depressive, bipolar and related disorders (12.04); intellectual disorder (12.05); anxiety and obsessive-compulsive disorders (12.06); somatic symptom and related disorders

(12.07); personality and impulse-control disorders (12.08); autism spectrum disorder (12.10); neurodevelopmental disorders (12.11); eating disorders (12.13); and trauma- and stressor-related disorders (12.15).

2. Listings 12.07, 12.08, 12.10, 12.11, and 12.13 have two paragraphs, designated A and B; your mental disorder must satisfy the requirements of both paragraphs A and B. Listings 12.02, 12.03, 12.04, 12.06, and 12.15 have three paragraphs, designated A, B, and C; your mental disorder must satisfy the requirements of both paragraphs A and B, or the requirements of both paragraphs A and C. Listing 12.05 has two paragraphs that are unique to that listing (see 12.00A3); your mental disorder must satisfy the requirements of either paragraph A or paragraph B.

a. Paragraph A of each listing (except 12.05) includes the medical criteria that must be present in your medical evidence.

b. Paragraph B of each listing (except 12.05) provides the functional criteria we assess, in conjunction with a rating scale (see 12.00E and 12.00F), to evaluate how your mental disorder limits your functioning. These criteria represent the areas of mental functioning a person uses in a work setting. They are: understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself. We will determine the degree to which your medically determinable mental impairment affects the four areas of mental functioning and your ability to function independently, appropriately, effectively, and on a sustained basis (see §§

404.1520a(c)(2) and 416.920a(c)(2) of this chapter). To satisfy the paragraph B criteria, your mental disorder must result in “extreme” limitation of one, or “marked” limitation of two, of the four areas of mental functioning. (When we refer to “paragraph B criteria” or “area[s] of mental functioning” in the introductory text of this body system, we mean the criteria in paragraph B of every listing except 12.05.)

c. Paragraph C of listings 12.02, 12.03, 12.04, 12.06, and 12.15 provides the criteria we use to evaluate “serious and persistent mental disorders.” To satisfy the paragraph C criteria, your mental disorder must be “serious and persistent”; that is, there must be a medically documented history of the existence of the disorder over a period of at least 2 years, and evidence that satisfies the criteria in both C1 and C2 (see 12.00G). (When we refer to “paragraph C” or “the paragraph C criteria” in the introductory text of this body system, we mean the criteria in paragraph C of listings 12.02, 12.03, 12.04, 12.06, and 12.15.)

3. Listing 12.05 has two paragraphs, designated A and B, that apply to only intellectual disorder. Each paragraph requires that you have significantly subaverage general intellectual functioning; significant deficits in current adaptive functioning; and evidence that demonstrates or supports (is consistent with) the conclusion that your disorder began prior to age 22.

B. Which mental disorders do we evaluate under each listing category?

1. Neurocognitive disorders (12.02).

a. These disorders are characterized by a clinically significant decline in cognitive functioning. Symptoms and signs may include, but are not limited to, disturbances in memory, executive functioning (that is, higher-level cognitive processes; for example, regulating attention, planning, inhibiting responses, decision-making), visual-spatial functioning, language and speech, perception, insight, judgment, and insensitivity to social standards.

b. Examples of disorders that we evaluate in this category include major neurocognitive disorder; dementia of the Alzheimer type; vascular dementia; dementia due to a medical condition such as a metabolic disease (for example, late-onset Tay-Sachs disease), human immunodeficiency virus infection, vascular malformation, progressive brain tumor, neurological disease (for example, multiple sclerosis, Parkinsonian syndrome, Huntington disease), or traumatic brain injury; or substance-induced cognitive disorder associated with drugs of abuse, medications, or toxins. (We evaluate neurological disorders under that body system (see 11.00). We evaluate cognitive impairments that result from neurological disorders under 12.02 if they do not satisfy the requirements in 11.00 (see 11.00G).)

c. This category does not include the mental disorders that we evaluate under intellectual disorder (12.05), autism spectrum disorder (12.10), and neurodevelopmental disorders (12.11).

2. Schizophrenia spectrum and other psychotic disorders (12.03).

a. These disorders are characterized by delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior, causing a clinically significant decline in functioning. Symptoms and signs may include, but are not limited to, inability to initiate and persist in goal-directed activities, social withdrawal, flat or inappropriate affect, poverty of thought and speech, loss of interest or pleasure, disturbances of mood, odd beliefs and mannerisms, and paranoia.

b. Examples of disorders that we evaluate in this category include schizophrenia, schizoaffective disorder, delusional disorder, and psychotic disorder due to another medical condition.

3. Depressive, bipolar and related disorders (12.04).

a. These disorders are characterized by an irritable, depressed, elevated, or expansive mood, or by a loss of interest or pleasure in all or almost all activities, causing a clinically significant decline in functioning. Symptoms and signs may include, but are not limited to, feelings of hopelessness or guilt, suicidal ideation, a clinically significant change in body weight or appetite, sleep disturbances, an increase or decrease in energy, psychomotor abnormalities, disturbed concentration, pressured speech, grandiosity, reduced impulse control, sadness, euphoria, and social withdrawal.

b. Examples of disorders that we evaluate in this category include bipolar disorders (I or II), cyclothymic disorder, major depressive disorder, persistent depressive disorder (dysthymia), and bipolar or depressive disorder due to another medical condition.

4. Intellectual disorder (12.05).

a. This disorder is characterized by significantly subaverage general intellectual functioning, significant deficits in current adaptive functioning, and manifestation of the disorder before age 22. Signs may include, but are not limited to, poor conceptual, social, or practical skills evident in your adaptive functioning.

b. The disorder that we evaluate in this category may be described in the evidence as intellectual disability, intellectual developmental disorder, or historically used terms such as “mental retardation.”

c. This category does not include the mental disorders that we evaluate under neurocognitive disorders (12.02), autism spectrum disorder (12.10), or neurodevelopmental disorders (12.11).

5. Anxiety and obsessive-compulsive disorders (12.06).

a. These disorders are characterized by excessive anxiety, worry, apprehension, and fear, or by avoidance of feelings, thoughts, activities, objects, places, or people. Symptoms and signs may include, but are not limited to, restlessness, difficulty concentrating, hyper-vigilance, muscle tension, sleep disturbance, fatigue, panic attacks, obsessions and compulsions, constant thoughts and fears about safety, and frequent physical complaints.

b. Examples of disorders that we evaluate in this category include social anxiety disorder, panic disorder, generalized anxiety disorder, agoraphobia, and obsessive-compulsive disorder.

c. This category does not include the mental disorders that we evaluate under trauma- and stressor-related disorders (12.15).

6. Somatic symptom and related disorders (12.07).

a. These disorders are characterized by physical symptoms or deficits that are not intentionally produced or feigned, and that, following clinical investigation, cannot be fully explained by a general medical condition, another mental disorder, the direct effects of a substance, or a culturally sanctioned behavior or experience. These disorders may also be characterized by a preoccupation with having or acquiring a serious medical condition that has not been identified or diagnosed. Symptoms and signs may include, but are not limited to, pain and other abnormalities of sensation, gastrointestinal

symptoms, fatigue, a high level of anxiety about personal health status, abnormal motor movement, pseudoseizures, and pseudoneurological symptoms, such as blindness or deafness.

b. Examples of disorders that we evaluate in this category include somatic symptom disorder, illness anxiety disorder, and conversion disorder.

7. Personality and impulse-control disorders (12.08).

a. These disorders are characterized by enduring, inflexible, maladaptive, and pervasive patterns of behavior. Onset typically occurs in adolescence or young adulthood. Symptoms and signs may include, but are not limited to, patterns of distrust, suspiciousness, and odd beliefs; social detachment, discomfort, or avoidance; hypersensitivity to negative evaluation; an excessive need to be taken care of; difficulty making independent decisions; a preoccupation with orderliness, perfectionism, and control; and inappropriate, intense, impulsive anger and behavioral expression grossly out of proportion to any external provocation or psychosocial stressors.

b. Examples of disorders that we evaluate in this category include paranoid, schizoid, schizotypal, borderline, avoidant, dependent, obsessive-compulsive personality disorders, and intermittent explosive disorder.

8. Autism spectrum disorder (12.10).

a. These disorders are characterized by qualitative deficits in the development of reciprocal social interaction, verbal and nonverbal communication skills, and symbolic or imaginative activity; restricted repetitive and stereotyped patterns of behavior, interests, and activities; and stagnation of development or loss of acquired skills early in life. Symptoms and signs may include, but are not limited to, abnormalities and unevenness in the development of cognitive skills; unusual responses to sensory stimuli; and behavioral difficulties, including hyperactivity, short attention span, impulsivity, aggressiveness, or self-injurious actions.

b. Examples of disorders that we evaluate in this category include autism spectrum disorder with or without accompanying intellectual impairment, and autism spectrum disorder with or without accompanying language impairment.

c. This category does not include the mental disorders that we evaluate under neurocognitive disorders (12.02), intellectual disorder (12.05), and neurodevelopmental disorders (12.11).

9. Neurodevelopmental disorders (12.11).

a. These disorders are characterized by onset during the developmental period, that is, during childhood or adolescence, although sometimes they are not diagnosed until adulthood. Symptoms and signs may include, but are not limited to, underlying

abnormalities in cognitive processing (for example, deficits in learning and applying verbal or nonverbal information, visual perception, memory, or a combination of these); deficits in attention or impulse control; low frustration tolerance; excessive or poorly planned motor activity; difficulty with organizing (time, space, materials, or tasks); repeated accidental injury; and deficits in social skills. Symptoms and signs specific to tic disorders include sudden, rapid, recurrent, non-rhythmic, motor movement or vocalization.

b. Examples of disorders that we evaluate in this category include specific learning disorder, borderline intellectual functioning, and tic disorders (such as Tourette syndrome).

c. This category does not include the mental disorders that we evaluate under neurocognitive disorders (12.02), autism spectrum disorder (12.10), or personality and impulse-control disorders (12.08).

10. Eating disorders (12.13).

a. These disorders are characterized by disturbances in eating behavior and preoccupation with, and excessive self-evaluation of, body weight and shape. Symptoms and signs may include, but are not limited to, restriction of energy consumption when compared with individual requirements; recurrent episodes of binge eating or behavior intended to prevent weight gain, such as self-induced vomiting, excessive exercise, or

misuse of laxatives; mood disturbances, social withdrawal, or irritability; amenorrhea; dental problems; abnormal laboratory findings; and cardiac abnormalities.

b. Examples of disorders that we evaluate in this category include anorexia nervosa, bulimia nervosa, binge-eating disorder, and avoidant/restrictive food disorder.

11. Trauma- and stressor-related disorders (12.15).

a. These disorders are characterized by experiencing or witnessing a traumatic or stressful event, or learning of a traumatic event occurring to a close family member or close friend, and the psychological aftermath of clinically significant effects on functioning. Symptoms and signs may include, but are not limited to, distressing memories, dreams, and flashbacks related to the trauma or stressor; avoidant behavior; diminished interest or participation in significant activities; persistent negative emotional states (for example, fear, anger) or persistent inability to experience positive emotions (for example, satisfaction, affection); anxiety; irritability; aggression; exaggerated startle response; difficulty concentrating; and sleep disturbance.

b. Examples of disorders that we evaluate in this category include posttraumatic stress disorder and other specified trauma- and stressor-related disorders (such as adjustment-like disorders with prolonged duration without prolonged duration of stressor).

c. This category does not include the mental disorders that we evaluate under anxiety and obsessive-compulsive disorders (12.06), and cognitive impairments that result from neurological disorders, such as a traumatic brain injury, which we evaluate under neurocognitive disorders (12.02).

C. What evidence do we need to evaluate your mental disorder?

1. General. We need evidence from an acceptable medical source to establish that you have a medically determinable mental disorder. We also need evidence to assess the severity of your mental disorder and its effects on your ability to function in a work setting. We will determine the extent and kinds of evidence we need from medical and non-medical sources based on the individual facts about your disorder. For additional evidence requirements for intellectual disorder (12.05), see 12.00H. For our basic rules on evidence, see §§ 404.1512, 404.1513, 404.1520b, 416.912, 416.913, and 416.920b of this chapter. For our rules on evaluating opinion evidence, see §§ 404.1527 and 416.927 of this chapter. For our rules on evidence about your symptoms, see §§ 404.1529 and 416.929 of this chapter.

2. Evidence from medical sources. We will consider all relevant medical evidence about your disorder from your physician, psychologist, and other medical sources, which include health care providers such as physician assistants, psychiatric nurse practitioners, licensed clinical social workers, and clinical mental health counselors. Evidence from your medical sources may include:

- a. Your reported symptoms.
- b. Your medical, psychiatric, and psychological history.
- c. The results of physical or mental status examinations, structured clinical interviews, psychiatric or psychological rating scales, measures of adaptive functioning, or other clinical findings.
- d. Psychological testing, imaging results, or other laboratory findings.
- e. Your diagnosis.
- f. The type, dosage, and beneficial effects of medications you take.
- g. The type, frequency, duration, and beneficial effects of therapy you receive.
- h. Side effects of medication or other treatment that limit your ability to function.
- i. Your clinical course, including changes in your medication, therapy, or other treatment, and the time required for therapeutic effectiveness.
- j. Observations and descriptions of how you function during examinations or

therapy.

k. Information about sensory, motor, or speech abnormalities, or about your cultural background (for example, language or customs) that may affect an evaluation of your mental disorder.

l. The expected duration of your symptoms and signs and their effects on your functioning, both currently and in the future.

3. Evidence from you and people who know you. We will consider all relevant evidence about your mental disorder and your daily functioning that we receive from you and from people who know you. We will ask about your symptoms, your daily functioning, and your medical treatment. We will ask for information from third parties who can tell us about your mental disorder, but you must give us permission to do so. This evidence may include information from your family, caregivers, friends, neighbors, clergy, case managers, social workers, shelter staff, or other community support and outreach workers. We will consider whether your statements and the statements from third parties are consistent with the medical and other evidence we have.

4. Evidence from school, vocational training, work, and work-related programs.

a. School. You may have recently attended or may still be attending school, and you may have received or may still be receiving special education services. If so, we will

try to obtain information from your school sources when we need it to assess how your mental disorder affects your ability to function. Examples of this information include your Individualized Education Programs (IEPs), your Section 504 plans, comprehensive evaluation reports, school-related therapy progress notes, information from your teachers about how you function in a classroom setting, and information about any special services or accommodations you receive at school.

b. Vocational training, work, and work-related programs. You may have recently participated in or may still be participating in vocational training, work-related programs, or work activity. If so, we will try to obtain information from your training program or your employer when we need it to assess how your mental disorder affects your ability to function. Examples of this information include training or work evaluations, modifications to your work duties or work schedule, and any special supports or accommodations you have required or now require in order to work. If you have worked or are working through a community mental health program, sheltered or supported work program, rehabilitation program, or transitional employment program, we will consider the type and degree of support you have received or are receiving in order to work (see 12.00D).

5. Need for longitudinal evidence.

a. General. Longitudinal medical evidence can help us learn how you function over time, and help us evaluate any variations in the level of your functioning. We will

request longitudinal evidence of your mental disorder when your medical providers have records concerning you and your mental disorder over a period of months or perhaps years (see §§ 404.1512(d) and 416.912(d) of this chapter).

b. Non-medical sources of longitudinal evidence. Certain situations, such as chronic homelessness, may make it difficult for you to provide longitudinal medical evidence. If you have a severe mental disorder, you will probably have evidence of its effects on your functioning over time, even if you have not had an ongoing relationship with the medical community or are not currently receiving treatment. For example, family members, friends, neighbors, former employers, social workers, case managers, community support staff, outreach workers, or government agencies may be familiar with your mental health history. We will ask for information from third parties who can tell us about your mental disorder, but you must give us permission to do so.

c. Absence of longitudinal evidence. In the absence of longitudinal evidence, we will use current objective medical evidence and all other relevant evidence available to us in your case record to evaluate your mental disorder. If we purchase a consultative examination to document your disorder, the record will include the results of that examination (see §§ 404.1514 and 416.914 of this chapter). We will take into consideration your medical history, symptoms, clinical and laboratory findings, and medical source opinions. If you do not have longitudinal evidence, the current evidence alone may not be sufficient or appropriate to show that you have a disorder that meets the criteria of one of the mental disorders listings. In that case, we will follow the rules in

12.00J.

6. Evidence of functioning in unfamiliar situations or supportive situations.

a. Unfamiliar situations. We recognize that evidence about your functioning in unfamiliar situations does not necessarily show how you would function on a sustained basis in a work setting. In one-time, time-limited, or other unfamiliar situations, you may function differently than you do in familiar situations. In unfamiliar situations, you may appear more, or less, limited than you do on a daily basis and over time.

b. Supportive situations. Your ability to complete tasks in settings that are highly structured, or that are less demanding or more supportive than typical work settings does not necessarily demonstrate your ability to complete tasks in the context of regular employment during a normal workday or work week.

c. Our assessment. We must assess your ability to complete tasks by evaluating all the evidence, such as reports about your functioning from you and third parties who are familiar with you, with an emphasis on how independently, appropriately, and effectively you are able to complete tasks on a sustained basis.

D. How do we consider psychosocial supports, structured settings, living arrangements, and treatment?

1. General. Psychosocial supports, structured settings, and living arrangements, including assistance from your family or others, may help you by reducing the demands made on you. In addition, treatment you receive may reduce your symptoms and signs and possibly improve your functioning, or may have side effects that limit your functioning. Therefore, when we evaluate the effects of your mental disorder and rate the limitation of your areas of mental functioning, we will consider the kind and extent of supports you receive, the characteristics of any structured setting in which you spend your time, and the effects of any treatment. This evidence may come from reports about your functioning from you or third parties who are familiar with you, and other third-party statements or information. Following are some examples of the supports you may receive:

a. You receive help from family members or other people who monitor your daily activities and help you to function. For example, family members administer your medications, remind you to eat, shop for you and pay your bills, or change their work hours so you are never home alone.

b. You participate in a special education or vocational training program, or a psychosocial rehabilitation day treatment or community support program, where you receive training in daily living and entry-level work skills.

c. You participate in a sheltered, supported, or transitional work program, or in a competitive employment setting with the help of a job coach or supervisor.

d. You receive comprehensive “24/7 wrap-around” mental health services while living in a group home or transitional housing, while participating in a semi-independent living program, or while living in individual housing (for example, your own home or apartment).

e. You live in a hospital or other institution with 24-hour care.

f. You receive assistance from a crisis response team, social workers, or community mental health workers who help you meet your physical needs, and who may also represent you in dealings with government or community social services.

g. You live alone and do not receive any psychosocial support(s); however, you have created a highly structured environment by eliminating all but minimally necessary contact with the world outside your living space.

2. How we consider different levels of support and structure in psychosocial rehabilitation programs.

a. Psychosocial rehabilitation programs are based on your specific needs.

Therefore, we cannot make any assumptions about your mental disorder based solely on the fact that you are associated with such a program. We must know the details of the program(s) in which you are involved and the pattern(s) of your involvement over time.

b. The kinds and levels of supports and structures in psychosocial rehabilitation programs typically occur on a scale of “most restrictive” to “least restrictive.”

Participation in a psychosocial rehabilitation program at the most restrictive level would suggest greater limitation of your areas of mental functioning than would participation at a less restrictive level. The length of time you spend at different levels in a program also provides information about your functioning. For example, you could begin participation at the most restrictive crisis intervention level but gradually improve to the point of readiness for a lesser level of support and structure and possibly some form of employment.

3. How we consider the help or support you receive.

a. We will consider the complete picture of your daily functioning, including the kinds, extent, and frequency of help and support you receive, when we evaluate your mental disorder and determine whether you are able to use the four areas of mental functioning in a work setting. The fact that you have done, or currently do, some routine activities without help or support does not necessarily mean that you do not have a mental disorder or that you are not disabled. For example, you may be able to take care of your personal needs, cook, shop, pay your bills, live by yourself, and drive a car. You may demonstrate both strengths and deficits in your daily functioning.

b. You may receive various kinds of help and support from others that enable you

to do many things that, because of your mental disorder, you might not be able to do independently. Your daily functioning may depend on the special contexts in which you function. For example, you may spend your time among only familiar people or surroundings, in a simple and steady routine or an unchanging environment, or in a highly structured setting. However, this does not necessarily show how you would function in a work setting on a sustained basis, throughout a normal workday and workweek. (See 12.00H for further discussion of these issues regarding significant deficits in adaptive functioning for the purpose of 12.05.)

4. How we consider treatment. We will consider the effect of any treatment on your functioning when we evaluate your mental disorder. Treatment may include medication(s), psychotherapy, or other forms of intervention, which you receive in a doctor's office, during a hospitalization, or in a day program at a hospital or outpatient treatment program. With treatment, you may not only have your symptoms and signs reduced, but may also be able to function in a work setting. However, treatment may not resolve all of the limitations that result from your mental disorder, and the medications you take or other treatment you receive for your disorder may cause side effects that limit your mental or physical functioning. For example, you may experience drowsiness, blunted affect, memory loss, or abnormal involuntary movements.

E. What are the paragraph B criteria?

1. Understand, remember, or apply information (paragraph B1). This area of

mental functioning refers to the abilities to learn, recall, and use information to perform work activities. Examples include: understanding and learning terms, instructions, procedures; following one- or two-step oral instructions to carry out a task; describing work activity to someone else; asking and answering questions and providing explanations; recognizing a mistake and correcting it; identifying and solving problems; sequencing multi-step activities; and using reason and judgment to make work-related decisions. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

2. Interact with others (paragraph B2). This area of mental functioning refers to the abilities to relate to and work with supervisors, co-workers, and the public. Examples include: cooperating with others; asking for help when needed; handling conflicts with others; stating own point of view; initiating or sustaining conversation; understanding and responding to social cues (physical, verbal, emotional); responding to requests, suggestions, criticism, correction, and challenges; and keeping social interactions free of excessive irritability, sensitivity, argumentativeness, or suspiciousness. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

3. Concentrate, persist, or maintain pace (paragraph B3). This area of mental functioning refers to the abilities to focus attention on work activities and stay on task at a sustained rate. Examples include: initiating and performing a task that you understand and know how to do; working at an appropriate and consistent pace; completing tasks in

a timely manner; ignoring or avoiding distractions while working; changing activities or work settings without being disruptive; working close to or with others without interrupting or distracting them; sustaining an ordinary routine and regular attendance at work; and working a full day without needing more than the allotted number or length of rest periods during the day. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

4. Adapt or manage oneself (paragraph B4). This area of mental functioning refers to the abilities to regulate emotions, control behavior, and maintain well-being in a work setting. Examples include: responding to demands; adapting to changes; managing your psychologically based symptoms; distinguishing between acceptable and unacceptable work performance; setting realistic goals; making plans for yourself independently of others; maintaining personal hygiene and attire appropriate to a work setting; and being aware of normal hazards and taking appropriate precautions. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples.

F. How do we use the paragraph B criteria to evaluate your mental disorder?

1. General. We use the paragraph B criteria, in conjunction with a rating scale (see 12.00F2), to rate the degree of your limitations. We consider only the limitations that result from your mental disorder(s). We will determine whether you are able to use each of the paragraph B areas of mental functioning in a work setting. We will consider,

for example, the kind, degree, and frequency of difficulty you would have; whether you could function without extra help, structure, or supervision; and whether you would require special conditions with regard to activities or other people (see 12.00D).

2. The five-point rating scale. We evaluate the effects of your mental disorder on each of the four areas of mental functioning based on a five-point rating scale consisting of none, mild, moderate, marked, and extreme limitation. To satisfy the paragraph B criteria, your mental disorder must result in extreme limitation of one, or marked limitation of two, paragraph B areas of mental functioning. Under these listings, the five rating points are defined as follows:

a. No limitation (or none). You are able to function in this area independently, appropriately, effectively, and on a sustained basis.

b. Mild limitation. Your functioning in this area independently, appropriately, effectively, and on a sustained basis is slightly limited.

c. Moderate limitation. Your functioning in this area independently, appropriately, effectively, and on a sustained basis is fair.

d. Marked limitation. Your functioning in this area independently, appropriately, effectively, and on a sustained basis is seriously limited.

e. Extreme limitation. You are not able to function in this area independently, appropriately, effectively, and on a sustained basis.

3. Rating the limitations of your areas of mental functioning.

a. General. We use all of the relevant medical and non-medical evidence in your case record to evaluate your mental disorder: the symptoms and signs of your disorder, the reported limitations in your activities, and any help and support you receive that is necessary for you to function. The medical evidence may include descriptors regarding the diagnostic stage or level of your disorder, such as “mild” or “moderate.” Clinicians may use these terms to characterize your medical condition. However, these terms will not always be the same as the degree of your limitation in a paragraph B area of mental functioning.

b. Areas of mental functioning in daily activities. You use the same four areas of mental functioning in daily activities at home and in the community that you would use to function at work. With respect to a particular task or activity, you may have trouble using one or more of the areas. For example, you may have difficulty understanding and remembering what to do; or concentrating and staying on task long enough to do it; or engaging in the task or activity with other people; or trying to do the task without becoming frustrated and losing self-control. Information about your daily functioning can help us understand whether your mental disorder limits one or more of these areas; and, if so, whether it also affects your ability to function in a work setting.

c. Areas of mental functioning in work settings. If you have difficulty using an area of mental functioning from day-to-day at home or in your community, you may also have difficulty using that area to function in a work setting. On the other hand, if you are able to use an area of mental functioning at home or in your community, we will not necessarily assume that you would also be able to use that area to function in a work setting where the demands and stressors differ from those at home. We will consider all evidence about your mental disorder and daily functioning before we reach a conclusion about your ability to work.

d. Overall effect of limitations. Limitation of an area of mental functioning reflects the overall degree to which your mental disorder interferes with that area. The degree of limitation is how we document our assessment of your limitation when using the area of mental functioning independently, appropriately, effectively, and on a sustained basis. It does not necessarily reflect a specific type or number of activities, including activities of daily living, that you have difficulty doing. In addition, no single piece of information (including test results) can establish the degree of limitation of an area of mental functioning.

e. Effects of support, supervision, structure on functioning. The degree of limitation of an area of mental functioning also reflects the kind and extent of supports or supervision you receive and the characteristics of any structured setting where you spend your time, which enable you to function. The more extensive the support you need from

others or the more structured the setting you need in order to function, the more limited we will find you to be (see 12.00D).

f. Specific instructions for paragraphs B1, B3, and B4. For paragraphs B1, B3, and B4, the greatest degree of limitation of any part of the area of mental functioning directs the rating of limitation of that whole area of mental functioning.

(i) To do a work-related task, you must be able to understand and remember and apply information required by the task. Similarly, you must be able to concentrate and persist and maintain pace in order to complete the task, and adapt and manage yourself in the workplace. Limitation in any one of these parts (understand or remember or apply; concentrate or persist or maintain pace; adapt or manage oneself) may prevent you from completing a work-related task.

(ii) We will document the rating of limitation of the whole area of mental functioning, not each individual part. We will not add ratings of the parts together. For example, with respect to paragraph B3, if you have marked limitation in maintaining pace, and mild or moderate limitations in concentrating and persisting, we will find that you have marked limitation in the whole paragraph B3 area of mental functioning.

(iii) Marked limitation in more than one part of the same paragraph B area of mental functioning does not satisfy the requirement to have marked limitation in two paragraph B areas of mental functioning.

4. How we evaluate mental disorders involving exacerbations and remissions.

a. When we evaluate the effects of your mental disorder, we will consider how often you have exacerbations and remissions, how long they last, what causes your mental disorder to worsen or improve, and any other relevant information. We will assess any limitation of the affected paragraph B area(s) of mental functioning using the rating scale for the paragraph B criteria. We will consider whether you can use the area of mental functioning on a regular and continuing basis (8 hours a day, 5 days a week, or an equivalent work schedule). We will not find that you are able to work solely because you have a period(s) of improvement (remission), or that you are disabled solely because you have a period of worsening (exacerbation), of your mental disorder.

b. If you have a mental disorder involving exacerbations and remissions, you may be able to use the four areas of mental functioning to work for a few weeks or months. Recurrence or worsening of symptoms and signs, however, can interfere enough to render you unable to sustain the work.

G. What are the paragraph C criteria, and how do we use them to evaluate your mental disorder?

1. General. The paragraph C criteria are an alternative to the paragraph B criteria under listings 12.02, 12.03, 12.04, 12.06, and 12.15. We use the paragraph C criteria to

evaluate mental disorders that are “serious and persistent.” In the paragraph C criteria, we recognize that mental health interventions may control the more obvious symptoms and signs of your mental disorder.

2. Paragraph C criteria.

a. We find a mental disorder to be “serious and persistent” when there is a medically documented history of the existence of the mental disorder in the listing category over a period of at least 2 years, and evidence shows that your disorder satisfies both C1 and C2.

b. The criterion in C1 is satisfied when the evidence shows that you rely, on an ongoing basis, upon medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s), to diminish the symptoms and signs of your mental disorder (see 12.00D). We consider that you receive ongoing medical treatment when the medical evidence establishes that you obtain medical treatment with a frequency consistent with accepted medical practice for the type of treatment or evaluation required for your medical condition. We will consider periods of inconsistent treatment or lack of compliance with treatment that may result from your mental disorder. If the evidence indicates that the inconsistent treatment or lack of compliance is a feature of your mental disorder, and it has led to an exacerbation of your symptoms and signs, we will not use it as evidence to support a finding that you have not received ongoing medical treatment as required by this paragraph.

c. The criterion in C2 is satisfied when the evidence shows that, despite your diminished symptoms and signs, you have achieved only marginal adjustment. “Marginal adjustment” means that your adaptation to the requirements of daily life is fragile; that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life. We will consider that you have achieved only marginal adjustment when the evidence shows that changes or increased demands have led to exacerbation of your symptoms and signs and to deterioration in your functioning; for example, you have become unable to function outside of your home or a more restrictive setting, without substantial psychosocial supports (see 12.00D). Such deterioration may have necessitated a significant change in medication or other treatment. Similarly, because of the nature of your mental disorder, evidence may document episodes of deterioration that have required you to be hospitalized or absent from work, making it difficult for you to sustain work activity over time.

H. How do we document and evaluate intellectual disorder under 12.05?

1. General. Listing 12.05 is based on the three elements that characterize intellectual disorder: significantly subaverage general intellectual functioning; significant deficits in current adaptive functioning; and the disorder manifested before age 22.

2. Establishing significantly subaverage general intellectual functioning.

a. Definition. Intellectual functioning refers to the general mental capacity to learn, reason, plan, solve problems, and perform other cognitive functions. Under 12.05A, we identify significantly subaverage general intellectual functioning by the cognitive inability to function at a level required to participate in standardized intelligence testing. Our findings under 12.05A are based on evidence from an acceptable medical source. Under 12.05B, we identify significantly subaverage general intellectual functioning by an IQ score(s) on an individually administered standardized test of general intelligence that meets program requirements and has a mean of 100 and a standard deviation of 15. A qualified specialist (see 12.00H2c) must administer the standardized intelligence testing.

b. Psychometric standards. We will find standardized intelligence test results usable for the purposes of 12.05B1 when the measure employed meets contemporary psychometric standards for validity, reliability, normative data, and scope of measurement; and a qualified specialist has individually administered the test according to all pre-requisite testing conditions.

c. Qualified specialist. A “qualified specialist” is currently licensed or certified at the independent level of practice in the State where the test was performed, and has the training and experience to administer, score, and interpret intelligence tests. If a psychological assistant or paraprofessional administered the test, a supervisory qualified specialist must interpret the test findings and co-sign the examination report.

d. Responsibility for conclusions based on testing. We generally presume that your obtained IQ score(s) is an accurate reflection of your general intellectual functioning, unless evidence in the record suggests otherwise. Examples of this evidence include: a statement from the test administrator indicating that your obtained score is not an accurate reflection of your general intellectual functioning, prior or internally inconsistent IQ scores, or information about your daily functioning. Only qualified specialists, Federal and State agency medical and psychological consultants, and other contracted medical and psychological experts may conclude that your obtained IQ score(s) is not an accurate reflection of your general intellectual functioning. This conclusion must be well supported by appropriate clinical and laboratory diagnostic techniques and must be based on relevant evidence in the case record, such as:

(i) The data obtained in testing;

(ii) Your developmental history, including when your signs and symptoms began;

(iii) Information about how you function on a daily basis in a variety of settings;

and

(iv) Clinical observations made during the testing period, such as your ability to sustain attention, concentration, and effort; to relate appropriately to the examiner; and to perform tasks independently without prompts or reminders.

3. Establishing significant deficits in adaptive functioning.

a. Definition. Adaptive functioning refers to how you learn and use conceptual, social, and practical skills in dealing with common life demands. It is your typical functioning at home and in the community, alone or among others. Under 12.05A, we identify significant deficits in adaptive functioning based on your dependence on others to care for your personal needs, such as eating and bathing. We will base our conclusions about your adaptive functioning on evidence from a variety of sources (see 12.00H3b) and not on your statements alone. Under 12.05B2, we identify significant deficits in adaptive functioning based on whether there is extreme limitation of one, or marked limitation of two, of the paragraph B criteria (see 12.00E; 12.00F).

b. Evidence. Evidence about your adaptive functioning may come from:

- (i) Medical sources, including their clinical observations;
- (ii) Standardized tests of adaptive functioning (see 12.00H3c);
- (iii) Third party information, such as a report of your functioning from a family member or friend;
- (iv) School records, if you were in school recently;

(v) Reports from employers or supervisors; and

(vi) Your own statements about how you handle all of your daily activities.

c. Standardized tests of adaptive functioning. We do not require the results of an individually administered standardized test of adaptive functioning. If your case record includes these test results, we will consider the results along with all other relevant evidence; however, we will use the guidelines in 12.00E and F to evaluate and determine the degree of your deficits in adaptive functioning, as required under 12.05B2.

d. How we consider common everyday activities.

(i) The fact that you engage in common everyday activities, such as caring for your personal needs, preparing simple meals, or driving a car, will not always mean that you do not have deficits in adaptive functioning as required by 12.05B2. You may demonstrate both strengths and deficits in your adaptive functioning. However, a lack of deficits in one area does not negate the presence of deficits in another area. When we assess your adaptive functioning, we will consider all of your activities and your performance of them.

(ii) Our conclusions about your adaptive functioning rest on whether you do your daily activities independently, appropriately, effectively, and on a sustained basis. If you receive help in performing your activities, we need to know the kind, extent, and

frequency of help you receive in order to perform them. We will not assume that your ability to do some common everyday activities, or to do some things without help or support, demonstrates that your mental disorder does not meet the requirements of 12.05B2. (See 12.00D regarding the factors we consider when we evaluate your functioning, including how we consider any help or support you receive.)

e. How we consider work activity. The fact that you have engaged in work activity, or that you work intermittently or steadily in a job commensurate with your abilities, will not always mean that you do not have deficits in adaptive functioning as required by 12.05B2. When you have engaged in work activity, we need complete information about the work, and about your functioning in the work activity and work setting, before we reach any conclusions about your adaptive functioning. We will consider all factors involved in your work history before concluding whether your impairment satisfies the criteria for intellectual disorder under 12.05B. We will consider your prior and current work history, if any, and various other factors influencing how you function. For example, we consider whether the work was in a supported setting, whether you required more supervision than other employees, how your job duties compared to others in the same job, how much time it took you to learn the job duties, and the reason the work ended, if applicable.

4. Establishing that the disorder began before age 22. We require evidence that demonstrates or supports (is consistent with) the conclusion that your mental disorder began prior to age 22. We do not require evidence that your impairment met all of the

requirements of 12.05A or 12.05B prior to age 22. Also, we do not require you to have met our statutory definition of disability prior to age 22. When we do not have evidence that was recorded before you attained age 22, we need evidence about your current intellectual and adaptive functioning and the history of your disorder that supports the conclusion that the disorder began before you attained age 22. Examples of evidence that can demonstrate or support this conclusion include:

- a. Tests of intelligence or adaptive functioning;
- b. School records indicating a history of special education services based on your intellectual functioning;
- c. An Individualized Education Program (IEP), including your transition plan;
- d. Reports of your academic performance and functioning at school;
- e. Medical treatment records;
- f. Interviews or reports from employers;
- g. Statements from a supervisor in a group home or a sheltered workshop; and
- h. Statements from people who have known you and can tell us about your

functioning in the past and currently.

I. How do we evaluate substance use disorders? If we find that you are disabled and there is medical evidence in your case record establishing that you have a substance use disorder, we will determine whether your substance use disorder is a contributing factor material to the determination of disability (see §§ 404.1535 and 416.935 of this chapter).

J. How do we evaluate mental disorders that do not meet one of the mental disorders listings?

1. These listings include only examples of mental disorders that we consider serious enough to prevent you from doing any gainful activity. If your severe mental disorder does not meet the criteria of any of these listings, we will consider whether you have an impairment(s) that meets the criteria of a listing in another body system. You may have another impairment(s) that is secondary to your mental disorder. For example, if you have an eating disorder and develop a cardiovascular impairment because of it, we will evaluate your cardiovascular impairment under the listings for the cardiovascular body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing (see §§ 404.1526 and 416.926 of this chapter).

3. If your impairment(s) does not meet or medically equal a listing, we will assess your residual functional capacity for engaging in substantial gainful activity (see §§ 404.1545 and 416.945 of this chapter). When we assess your residual functional capacity, we consider all of your impairment-related mental and physical limitations. For example, the side effects of some medications may reduce your general alertness, concentration, or physical stamina, affecting your residual functional capacity for non-exertional or exertional work activities. Once we have determined your residual functional capacity, we proceed to the fourth, and if necessary, the fifth steps of the sequential evaluation process in §§ 404.1520 and 416.920 of this chapter. We use the rules in §§ 404.1594 and 416.994 of this chapter, as appropriate, when we decide whether you continue to be disabled.

12.01 Category of Impairments, Mental Disorders

12.02 Neurocognitive disorders (see 12.00B1), satisfied by A and B, or A and C:

A. Medical documentation of a significant cognitive decline from a prior level of functioning in one or more of the cognitive areas:

1. Complex attention;

2. Executive function;

3. Learning and memory;

4. Language;

5. Perceptual-motor; or

6. Social cognition.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).

2. Interact with others (see 12.00E2).

3. Concentrate, persist, or maintain pace (see 12.00E3).

4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is “serious and persistent,” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); and

2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

12.03 Schizophrenia spectrum and other psychotic disorders (see 12.00B2), satisfied by A and B, or A and C:

A. Medical documentation of one or more of the following:

1. Delusions or hallucinations;

2. Disorganized thinking (speech); or

3. Grossly disorganized behavior or catatonia.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).
2. Interact with others (see 12.00E2).
3. Concentrate, persist, or maintain pace (see 12.00E3).
4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is “serious and persistent,” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); and

2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

12.04 Depressive, bipolar and related disorders (see 12.00B3), satisfied by A and B, or A and C:

A. Medical documentation of the requirements of paragraph 1 or 2:

1. Depressive disorder, characterized by five or more of the following:

a. Depressed mood;

b. Diminished interest in almost all activities;

c. Appetite disturbance with change in weight;

d. Sleep disturbance;

e. Observable psychomotor agitation or retardation;

f. Decreased energy;

g. Feelings of guilt or worthlessness;

h. Difficulty concentrating or thinking; or

i. Thoughts of death or suicide.

2. Bipolar disorder, characterized by three or more of the following:

a. Pressured speech;

b. Flight of ideas;

c. Inflated self-esteem;

d. Decreased need for sleep;

e. Distractibility;

f. Involvement in activities that have a high probability of painful consequences that are not recognized; or

g. Increase in goal-directed activity or psychomotor agitation.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).
2. Interact with others (see 12.00E2).
3. Concentrate, persist, or maintain pace (see 12.00E3).
4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is “serious and persistent,” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); and

2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

12.05 Intellectual disorder (see 12.00B4), satisfied by A or B:

A. Satisfied by 1, 2, and 3 (see 12.00H):

1. Significantly subaverage general intellectual functioning evident in your cognitive inability to function at a level required to participate in standardized testing of intellectual functioning; and

2. Significant deficits in adaptive functioning currently manifested by your dependence upon others for personal needs (for example, toileting, eating, dressing, or bathing); and

3. The evidence about your current intellectual and adaptive functioning and about the history of your disorder demonstrates or supports the conclusion that the disorder began prior to your attainment of age 22.

OR

B. Satisfied by 1, 2, and 3 (see 12.00H):

1. Significantly subaverage general intellectual functioning evidenced by a or b:

a. A full scale (or comparable) IQ score of 70 or below on an individually administered standardized test of general intelligence; or

b. A full scale (or comparable) IQ score of 71-75 accompanied by a verbal or performance IQ score (or comparable part score) of 70 or below on an individually administered standardized test of general intelligence; and

2. Significant deficits in adaptive functioning currently manifested by extreme limitation of one, or marked limitation of two, of the following areas of mental functioning:

a. Understand, remember, or apply information (see 12.00E1); or

b. Interact with others (see 12.00E2); or

c. Concentrate, persist, or maintain pace (see 12.00E3); or

d. Adapt or manage oneself (see 12.00E4); and

3. The evidence about your current intellectual and adaptive functioning and about the history of your disorder demonstrates or supports the conclusion that the disorder began prior to your attainment of age 22.

12.06 Anxiety and obsessive-compulsive disorders (see 12.00B5), satisfied by A and B, or A and C:

A. Medical documentation of the requirements of paragraph 1, 2, or 3:

1. Anxiety disorder, characterized by three or more of the following;

a. Restlessness;

b. Easily fatigued;

c. Difficulty concentrating;

d. Irritability;

e. Muscle tension; or

f. Sleep disturbance.

2. Panic disorder or agoraphobia, characterized by one or both:

a. Panic attacks followed by a persistent concern or worry about additional panic attacks or their consequences; or

b. Disproportionate fear or anxiety about at least two different situations (for example, using public transportation, being in a crowd, being in a line, being outside of your home, being in open spaces).

3. Obsessive-compulsive disorder, characterized by one or both:

a. Involuntary, time-consuming preoccupation with intrusive, unwanted thoughts;
or

b. Repetitive behaviors aimed at reducing anxiety.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).

2. Interact with others (see 12.00E2).

3. Concentrate, persist, or maintain pace (see 12.00E3).

4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is “serious and persistent;” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); and

2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

12.07 Somatic symptom and related disorders (see 12.00B6), satisfied by A and B:

A. Medical documentation of one or more of the following:

1. Symptoms of altered voluntary motor or sensory function that are not better explained by another medical or mental disorder;

2. One or more somatic symptoms that are distressing, with excessive thoughts, feelings, or behaviors related to the symptoms; or

3. Preoccupation with having or acquiring a serious illness without significant symptoms present.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).

2. Interact with others (see 12.00E2).

3. Concentrate, persist, or maintain pace (see 12.00E3).

4. Adapt or manage oneself (see 12.00E4).

12.08 Personality and impulse-control disorders (see 12.00B7), satisfied by A and

B:

A. Medical documentation of a pervasive pattern of one or more of the following:

1. Distrust and suspiciousness of others;
2. Detachment from social relationships;
3. Disregard for and violation of the rights of others;
4. Instability of interpersonal relationships;
5. Excessive emotionality and attention seeking;
6. Feelings of inadequacy;
7. Excessive need to be taken care of;
8. Preoccupation with perfectionism and orderliness; or
9. Recurrent, impulsive, aggressive behavioral outbursts.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).
2. Interact with others (see 12.00E2).
3. Concentrate, persist, or maintain pace (see 12.00E3).
4. Adapt or manage oneself (see 12.00E4).

12.09 [Reserved]

12.10 Autism spectrum disorder (see 12.00B8), satisfied by A and B:

A. Medical documentation of both of the following:

1. Qualitative deficits in verbal communication, nonverbal communication, and social interaction; and

2. Significantly restricted, repetitive patterns of behavior, interests, or activities.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).
2. Interact with others (see 12.00E2).
3. Concentrate, persist, or maintain pace (see 12.00E3).
4. Adapt or manage oneself (see 12.00E4).

12.11 Neurodevelopmental disorders (see 12.00B9), satisfied by A and B:

A. Medical documentation of the requirements of paragraph 1, 2, or 3:

1. One or both of the following:

a. Frequent distractibility, difficulty sustaining attention, and difficulty organizing tasks; or

b. Hyperactive and impulsive behavior (for example, difficulty remaining seated, talking excessively, difficulty waiting, appearing restless, or behaving as if being “driven by a motor”).

2. Significant difficulties learning and using academic skills; or

3. Recurrent motor movement or vocalization.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).

2. Interact with others (see 12.00E2).

3. Concentrate, persist, or maintain pace (see 12.00E3).

4. Adapt or manage oneself (see 12.00E4).

12.12 [Reserved]

12.13 Eating disorders (see 12.00B10), satisfied by A and B:

A. Medical documentation of a persistent alteration in eating or eating-related behavior that results in a change in consumption or absorption of food and that significantly impairs physical or psychological health.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).
2. Interact with others (see 12.00E2).
3. Concentrate, persist, or maintain pace (see 12.00E3).
4. Adapt or manage oneself (see 12.00E4).

12.15 Trauma- and stressor-related disorders (see 12.00B11), satisfied by A and B, or A and C:

A. Medical documentation of all of the following:

1. Exposure to actual or threatened death, serious injury, or violence;
2. Subsequent involuntary re-experiencing of the traumatic event (for example, intrusive memories, dreams, or flashbacks);
3. Avoidance of external reminders of the event;
4. Disturbance in mood and behavior; and
5. Increases in arousal and reactivity (for example, exaggerated startle response, sleep disturbance).

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 12.00F):

1. Understand, remember, or apply information (see 12.00E1).
2. Interact with others (see 12.00E2).

3. Concentrate, persist, or maintain pace (see 12.00E3).

4. Adapt or manage oneself (see 12.00E4).

OR

C. Your mental disorder in this listing category is “serious and persistent,” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); and

2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c).

* * * * *

Part B

* * * * *

112.00 Mental Disorders

A. How are the listings for mental disorders for children arranged, and what do they require?

1. The listings for mental disorders for children are arranged in 12 categories: neurocognitive disorders (112.02); schizophrenia spectrum and other psychotic disorders (112.03); depressive, bipolar and related disorders (112.04); intellectual disorder (112.05); anxiety and obsessive-compulsive disorders (112.06); somatic symptom and related disorders (112.07); personality and impulse-control disorders (112.08); autism spectrum disorder (112.10); neurodevelopmental disorders (112.11); eating disorders (112.13); developmental disorders in infants and toddlers (112.14); and trauma- and stressor-related disorders (112.15). All of these listings, with the exception of 112.14, apply to children from age three to attainment of age 18. Listing 112.14 is for children from birth to attainment of age 3.

2. Listings 112.07, 112.08, 112.10, 112.11, 112.13, and 112.14 have two paragraphs, designated A and B; your mental disorder must satisfy the requirements of both paragraphs A and B. Listings 112.02, 112.03, 112.04, 112.06, and 112.15 have three paragraphs, designated A, B, and C; your mental disorder must satisfy the requirements of both paragraphs A and B, or the requirements of both paragraphs A and C. Listing 112.05 has two paragraphs that are unique to that listing (see 112.00A3); your

mental disorder must satisfy the requirements of either paragraph A or paragraph B.

a. Paragraph A of each listing (except 112.05) includes the medical criteria that must be present in your medical evidence.

b. Paragraph B of each listing (except 112.05) provides the functional criteria we assess to evaluate how your mental disorder limits your functioning. For children ages 3 to 18, these criteria represent the areas of mental functioning a child uses to perform age-appropriate activities. They are: understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself. (See 112.00I for a discussion of the criteria for children from birth to attainment of age 3 under 112.14.) We will determine the degree to which your medically determinable mental impairment affects the four areas of mental functioning and your ability to function age-appropriately in a manner comparable to that of other children your age who do not have impairments. (Hereinafter, the words “age-appropriately” incorporate the qualifying statement, “in a manner comparable to that of other children your age who do not have impairments.”) To satisfy the paragraph B criteria, your mental disorder must result in “extreme” limitation of one, or “marked” limitation of two, of the four areas of mental functioning. (When we refer to “paragraph B criteria” or “area[s] of mental functioning” in the introductory text of this body system, we mean the criteria in paragraph B of every listing except 112.05 and 112.14.)

c. Paragraph C of listings 112.02, 112.03, 112.04, 112.06, and 112.15 provides the

criteria we use to evaluate “serious and persistent mental disorders.” To satisfy the paragraph C criteria, your mental disorder must be “serious and persistent”; that is, there must be a medically documented history of the existence of the disorder over a period of at least 2 years, and evidence that satisfies the criteria in both C1 and C2 (see 112.00G). (When we refer to “paragraph C” or “the paragraph C criteria” in the introductory text of this body system, we mean the criteria in paragraph C of listings 112.02, 112.03, 112.04, 112.06, and 112.15.)

3. Listing 112.05 has two paragraphs, designated A and B, that apply to only intellectual disorder. Each paragraph requires that you have significantly subaverage general intellectual functioning and significant deficits in current adaptive functioning.

B. Which mental disorders do we evaluate under each listing category for children?

1. Neurocognitive disorders (112.02).

a. These disorders are characterized in children by a clinically significant deviation in normal cognitive development or by a decline in cognitive functioning. Symptoms and signs may include, but are not limited to, disturbances in memory, executive functioning (that is, higher-level cognitive processes; for example, regulating attention, planning, inhibiting responses, decision-making), visual-spatial functioning, language and speech, perception, insight, and judgment.

b. Examples of disorders that we evaluate in this category include major neurocognitive disorder; mental impairments resulting from medical conditions such as a metabolic disease (for example, juvenile Tay-Sachs disease), human immunodeficiency virus infection, vascular malformation, progressive brain tumor, or traumatic brain injury; or substance-induced cognitive disorder associated with drugs of abuse, medications, or toxins. (We evaluate neurological disorders under that body system (see 111.00). We evaluate cognitive impairments that result from neurological disorders under 112.02 if they do not satisfy the requirements in 111.00. We evaluate catastrophic genetic disorders under listings in 110.00, 111.00, or 112.00, as appropriate. We evaluate genetic disorders that are not catastrophic under the affected body system(s).)

c. This category does not include the mental disorders that we evaluate under intellectual disorder (112.05), autism spectrum disorder (112.10), and neurodevelopmental disorders (112.11).

2. Schizophrenia spectrum and other psychotic disorders (112.03).

a. These disorders are characterized by delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior, causing a clinically significant decline in functioning. Symptoms and signs may include, but are not limited to, inability to initiate and persist in goal-directed activities, social withdrawal, flat or inappropriate affect, poverty of thought and speech, loss of interest or pleasure, disturbances of mood,

odd beliefs and mannerisms, and paranoia.

b. Examples of disorders that we evaluate in this category include schizophrenia, schizoaffective disorder, delusional disorder, and psychotic disorder due to another medical condition.

3. Depressive, bipolar and related disorders (112.04).

a. These disorders are characterized by an irritable, depressed, elevated, or expansive mood, or by a loss of interest or pleasure in all or almost all activities, causing a clinically significant decline in functioning. Symptoms and signs may include, but are not limited to, feelings of hopelessness or guilt, suicidal ideation, a clinically significant change in body weight or appetite, sleep disturbances, an increase or decrease in energy, psychomotor abnormalities, disturbed concentration, pressured speech, grandiosity, reduced impulse control, sadness, euphoria, and social withdrawal. Depending on a child's age and developmental stage, certain features, such as somatic complaints, irritability, anger, aggression, and social withdrawal may be more commonly present than other features.

b. Examples of disorders that we evaluate in this category include bipolar disorders (I or II), cyclothymic disorder, disruptive mood dysregulation disorder, major depressive disorder, persistent depressive disorder (dysthymia), and bipolar or depressive disorder due to another medical condition.

4. Intellectual disorder (112.05).

a. This disorder is characterized by significantly subaverage general intellectual functioning and significant deficits in current adaptive functioning. Signs may include, but are not limited to, poor conceptual, social, or practical skills evident in your adaptive functioning.

b. The disorder that we evaluate in this category may be described in the evidence as intellectual disability, intellectual developmental disorder, or historically used terms such as “mental retardation.”

c. This category does not include the mental disorders that we evaluate under neurocognitive disorders (112.02), autism spectrum disorder (112.10), or neurodevelopmental disorders (112.11).

5. Anxiety and obsessive-compulsive disorders (112.06).

a. These disorders are characterized by excessive anxiety, worry, apprehension, and fear, or by avoidance of feelings, thoughts, activities, objects, places, or people. Symptoms and signs may include, but are not limited to, restlessness, difficulty concentrating, hyper-vigilance, muscle tension, sleep disturbance, fatigue, panic attacks, obsessions and compulsions, constant thoughts and fears about safety, and frequent

physical complaints. Depending on a child's age and developmental stage, other features may also include refusal to go to school, academic failure, frequent stomachaches and other physical complaints, extreme worries about sleeping away from home, being overly clinging, and exhibiting tantrums at times of separation from caregivers.

b. Examples of disorders that we evaluate in this category include separation anxiety disorder, social anxiety disorder, panic disorder, generalized anxiety disorder, agoraphobia, and obsessive-compulsive disorder.

c. This category does not include the mental disorders that we evaluate under trauma- and stressor-related disorders (112.15).

6. Somatic symptom and related disorders (112.07).

a. These disorders are characterized by physical symptoms or deficits that are not intentionally produced or feigned, and that, following clinical investigation, cannot be fully explained by a general medical condition, another mental disorder, the direct effects of a substance, or a culturally sanctioned behavior or experience. Symptoms and signs may include, but are not limited to, pain and other abnormalities of sensation, gastrointestinal symptoms, fatigue, abnormal motor movement, pseudoseizures, and pseudoneurological symptoms, such as blindness or deafness.

b. Examples of disorders that we evaluate in this category include somatic

symptom disorder and conversion disorder.

7. Personality and impulse-control disorders (112.08).

a. These disorders are characterized by enduring, inflexible, maladaptive, and pervasive patterns of behavior. Onset may occur in childhood but more typically occurs in adolescence or young adulthood. Symptoms and signs may include, but are not limited to, patterns of distrust, suspiciousness, and odd beliefs; social detachment, discomfort, or avoidance; hypersensitivity to negative evaluation; an excessive need to be taken care of; difficulty making independent decisions; a preoccupation with orderliness, perfectionism, and control; and inappropriate, intense, impulsive anger and behavioral expression grossly out of proportion to any external provocation or psychosocial stressors.

b. Examples of disorders that we evaluate in this category include paranoid, schizoid, schizotypal, borderline, avoidant, dependent, obsessive-compulsive personality disorders, and intermittent explosive disorder.

8. Autism spectrum disorder (112.10).

a. These disorders are characterized by qualitative deficits in the development of reciprocal social interaction, verbal and nonverbal communication skills, and symbolic or imaginative play; restricted repetitive and stereotyped patterns of behavior, interests, and activities; and stagnation of development or loss of acquired skills. Symptoms and signs

may include, but are not limited to, abnormalities and unevenness in the development of cognitive skills; unusual responses to sensory stimuli; and behavioral difficulties, including hyperactivity, short attention span, impulsivity, aggressiveness, or self-injurious actions.

b. Examples of disorders that we evaluate in this category include autism spectrum disorder with or without accompanying intellectual impairment, and autism spectrum disorder with or without accompanying language impairment.

c. This category does not include the mental disorders that we evaluate under neurocognitive disorders (112.02), intellectual disorder (112.05), and neurodevelopmental disorders (112.11).

9. Neurodevelopmental disorders (112.11).

a. These disorders are characterized by onset during the developmental period, that is, during childhood or adolescence, although sometimes they are not diagnosed until adulthood. Symptoms and signs may include, but are not limited to, underlying abnormalities in cognitive processing (for example, deficits in learning and applying verbal or nonverbal information, visual perception, memory, or a combination of these); deficits in attention or impulse control; low frustration tolerance; excessive or poorly planned motor activity; difficulty with organizing (time, space, materials, or tasks); repeated accidental injury; and deficits in social skills. Symptoms and signs specific to

tic disorders include sudden, rapid, recurrent, non-rhythmic, motor movement or vocalization.

b. Examples of disorders that we evaluate in this category include specific learning disorder, borderline intellectual functioning, and tic disorders (such as Tourette syndrome).

c. This category does not include the mental disorders that we evaluate under neurocognitive disorders (112.02), autism spectrum disorder (112.10), or personality and impulse-control disorders (112.08).

10. Eating disorders (112.13).

a. These disorders are characterized in young children by persistent eating of nonnutritive substances or repeated episodes of regurgitation and re-chewing of food, or by persistent failure to consume adequate nutrition by mouth. In adolescence, these disorders are characterized by disturbances in eating behavior and preoccupation with, and excessive self-evaluation of, body weight and shape. Symptoms and signs may include, but are not limited to, failure to make expected weight gains; restriction of energy consumption when compared with individual requirements; recurrent episodes of binge eating or behavior intended to prevent weight gain, such as self-induced vomiting, excessive exercise, or misuse of laxatives; mood disturbances, social withdrawal, or irritability; amenorrhea; dental problems; abnormal laboratory findings; and cardiac

abnormalities.

b. Examples of disorders that we evaluate in this category include anorexia nervosa, bulimia nervosa, binge-eating disorder, and avoidant/restrictive food disorder.

11. Developmental disorders in infants and toddlers (112.14).

a. Developmental disorders are characterized by a delay or deficit in the development of age-appropriate skills, or a loss of previously acquired skills, involving motor planning and control, learning, relating and communicating, and self-regulating.

b. Examples of disorders that we evaluate in this category include developmental coordination disorder, separation anxiety disorder, autism spectrum disorder, and regulation disorders of sensory processing (difficulties in regulating emotions, behaviors, and motor abilities in response to sensory stimulation). Some infants and toddlers may have only a general diagnosis of “developmental delay.”

c. This category does not include eating disorders related to low birth weight and failure to thrive, which we evaluate under that body system (100.00).

12. Trauma- and stressor-related disorders (112.15).

a. These disorders are characterized by experiencing or witnessing a traumatic or

stressful event, or learning of a traumatic event occurring to a close family member or close friend, and the psychological aftermath of clinically significant effects on functioning. Symptoms and signs may include, but are not limited to, distressing memories, dreams, and flashbacks related to the trauma or stressor; avoidant or withdrawn behavior; constriction of play and significant activities; increased frequency of negative emotional states (for example, fear, sadness) or reduced expression of positive emotions (for example, satisfaction, affection); anxiety; irritability; aggression; exaggerated startle response; difficulty concentrating; sleep disturbance; and a loss of previously acquired developmental skills.

b. Examples of disorders that we evaluate in this category include posttraumatic stress disorder, reactive attachment disorder, and other specified trauma- and stressor-related disorders (such as adjustment-like disorders with prolonged duration without prolonged duration of stressor).

c. This category does not include the mental disorders that we evaluate under anxiety and obsessive-compulsive disorders (112.06), and cognitive impairments that result from neurological disorders, such as a traumatic brain injury, which we evaluate under neurocognitive disorders (112.02).

C. What evidence do we need to evaluate your mental disorder?

1. General. We need evidence from an acceptable medical source to establish that

you have a medically determinable mental disorder. We also need evidence to assess the severity of your mental disorder and its effects on your ability to function age-appropriately. We will determine the extent and kinds of evidence we need from medical and non-medical sources based on the individual facts about your disorder. For additional evidence requirements for intellectual disorder (112.05), see 112.00H. For our basic rules on evidence, see §§ 416.912, 416.913, and 416.920b of this chapter. For our rules on evaluating opinion evidence, see § 416.927 of this chapter. For our rules on evidence about your symptoms, see § 416.929 of this chapter.

2. Evidence from medical sources. We will consider all relevant medical evidence about your disorder from your physician, psychologist, and other medical sources, which include health care providers such as physician assistants, psychiatric nurse practitioners, licensed clinical social workers, and clinical mental health counselors. Evidence from your medical sources may include:

- a. Your reported symptoms.
- b. Your developmental, medical, psychiatric, and psychological history.
- c. The results of physical or mental status examinations, structured clinical interviews, psychiatric or psychological rating scales, measures of adaptive functioning, or other clinical findings.

d. Developmental assessments, psychological testing, imaging results, or other laboratory findings.

e. Your diagnosis.

f. The type, dosage, and beneficial effects of medications you take.

g. The type, frequency, duration, and beneficial effects of therapy you receive.

h. Side effects of medication or other treatment that limit your ability to function.

i. Your clinical course, including changes in your medication, therapy, or other treatment, and the time required for therapeutic effectiveness.

j. Observations and descriptions of how you function during examinations or therapy.

k. Information about sensory, motor, or speech abnormalities, or about your cultural background (for example, language or customs) that may affect an evaluation of your mental disorder.

l. The expected duration of your symptoms and signs and their effects on your ability to function age-appropriately, both currently and in the future.

3. Evidence from you and people who know you. We will consider all relevant evidence about your mental disorder and your daily functioning that we receive from you and from people who know you. If you are too young or unable to describe your symptoms and your functioning, we will ask for a description from the person who is most familiar with you. We will ask about your symptoms, your daily functioning, and your medical treatment. We will ask for information from third parties who can tell us about your mental disorder, but we must have permission to do so. This evidence may include information from your family, caregivers, teachers, other educators, neighbors, clergy, case managers, social workers, shelter staff, or other community support and outreach workers. We will consider whether your statements and the statements from third parties are consistent with the medical and other evidence we have.

4. Evidence from early intervention programs, school, vocational training, work, and work-related programs.

a. Early intervention programs. You may receive services in an Early Intervention Program (EIP) to help you with your developmental needs. If so, we will consider information from your Individualized Family Service Plan (IFSP) and the early intervention specialists who help you.

b. School. You may receive special education or related services at your preschool or school. If so, we will try to obtain information from your school sources when we

need it to assess how your mental disorder affects your ability to function. Examples of this information include your Individualized Education Programs (IEPs), your Section 504 plans, comprehensive evaluation reports, school-related therapy progress notes, information from your teachers about how you function in a classroom setting, and information from special educators, nurses, school psychologists, and occupational, physical, and speech/language therapists about any special education services or accommodations you receive at school.

c. Vocational training, work, and work-related programs. You may have recently participated in or may still be participating in vocational training, work-related programs, or work activity. If so, we will try to obtain information from your training program or your employer when we need it to assess how your mental disorder affects your ability to function. Examples of this information include training or work evaluations, modifications to your work duties or work schedule, and any special supports or accommodations you have required or now require in order to work. If you have worked or are working through a community mental health program, sheltered or supported work program, rehabilitation program, or transitional employment program, we will consider the type and degree of support you have received or are receiving in order to work (see 112.00D).

5. Need for longitudinal evidence.

a. General. Longitudinal medical evidence can help us learn how you function

over time, and help us evaluate any variations in the level of your functioning. We will request longitudinal evidence of your mental disorder when your medical providers have records concerning you and your mental disorder over a period of months or perhaps years (see § 416.912(d) of this chapter).

b. Non-medical sources of longitudinal evidence. Certain situations, such as chronic homelessness, may make it difficult for you to provide longitudinal medical evidence. If you have a severe mental disorder, you will probably have evidence of its effects on your functioning over time, even if you have not had an ongoing relationship with the medical community or are not currently receiving treatment. For example, family members, caregivers, teachers, neighbors, former employers, social workers, case managers, community support staff, outreach workers, or government agencies may be familiar with your mental health history. We will ask for information from third parties who can tell us about your mental disorder, but you must give us permission to do so.

c. Absence of longitudinal evidence. In the absence of longitudinal evidence, we will use current objective medical evidence and all other relevant evidence available to us in your case record to evaluate your mental disorder. If we purchase a consultative examination to document your disorder, the record will include the results of that examination (see § 416.914 of this chapter). We will take into consideration your medical history, symptoms, clinical and laboratory findings, and medical source opinions. If you do not have longitudinal evidence, the current evidence alone may not be sufficient or appropriate to show that you have a disorder that meets the criteria of one of the

mental disorders listings. In that case, we will follow the rules in 112.00K.

6. Evidence of functioning in unfamiliar situations or supportive situations.

a. Unfamiliar situations. We recognize that evidence about your functioning in unfamiliar situations does not necessarily show how you would function on a sustained basis in a school or other age-appropriate setting. In one-time, time-limited, or other unfamiliar situations, you may function differently than you do in familiar situations. In unfamiliar situations, you may appear more, or less, limited than you do on a daily basis and over time.

b. Supportive situations. Your ability to function in settings that are highly structured, or that are less demanding or more supportive than settings in which children your age without impairments typically function, does not necessarily demonstrate your ability to function age-appropriately.

c. Our assessment. We must assess your ability to function age-appropriately by evaluating all the evidence, such as reports about your functioning from third parties who are familiar with you, with an emphasis on how well you can initiate, sustain, and complete age-appropriate activities despite your impairment(s), compared to other children your age who do not have impairments.

D. How do we consider psychosocial supports, structured settings, living

arrangements, and treatment when we evaluate the functioning of children?

1. General. Psychosocial supports, structured settings, and living arrangements, including assistance from your family or others, may help you by reducing the demands made on you. In addition, treatment you receive may reduce your symptoms and signs and possibly improve your functioning, or may have side effects that limit your functioning. Therefore, when we evaluate the effects of your mental disorder and rate the limitation of your areas of mental functioning, we will consider the kind and extent of supports you receive, the characteristics of any structured setting in which you spend your time (compared to children your age without impairments), and the effects of any treatment. This evidence may come from reports about your functioning from third parties who are familiar with you, and other third-party statements or information. Following are some examples of the supports you may receive:

a. You receive help from family members or other people in ways that children your age without impairments typically do not need in order to function age-appropriately. For example, an aide may accompany you on the school bus to help you control your actions or to monitor you to ensure you do not injure yourself or others.

b. You receive one-on-one assistance in your classes every day; or you have a full-time personal aide who helps you to function in your classroom; or you are a student in a self-contained classroom; or you attend a separate or alternative school where you receive special education services.

c. You participate in a special education or vocational training program, or a psychosocial rehabilitation day treatment or community support program, where you receive training in daily living and entry-level work skills.

d. You participate in a sheltered, supported, or transitional work program, or in a competitive employment setting with the help of a job coach or supervisor.

e. You receive comprehensive “24/7 wrap-around” mental health services while living in a group home or transitional housing, while participating in a semi-independent living program, or while living at home.

f. You live in a residential school, hospital, or other institution with 24-hour care.

g. You receive assistance from a crisis response team, social workers, or community mental health workers who help you meet your physical needs, and who may also represent you in dealings with government or community social services.

2. How we consider different levels of support and structure in psychosocial rehabilitation programs.

a. Psychosocial rehabilitation programs are based on your specific needs.
Therefore, we cannot make any assumptions about your mental disorder based solely on

the fact that you are associated with such a program. We must know the details of the program(s) in which you are involved and the pattern(s) of your involvement over time.

b. The kinds and levels of supports and structures in psychosocial rehabilitation programs typically occur on a scale of “most restrictive” to “least restrictive.”

Participation in a psychosocial rehabilitation program at the most restrictive level would suggest greater limitation of your areas of mental functioning than would participation at a less restrictive level. The length of time you spend at different levels in a program also provides information about your functioning. For example, you could begin participation at the most restrictive crisis intervention level but gradually improve to the point of readiness for a lesser level of support and structure and, if you are an older adolescent, possibly some form of employment.

3. How we consider the help or support you receive.

a. We will consider the complete picture of your daily functioning, including the kinds, extent, and frequency of help and support you receive, when we evaluate your mental disorder and determine whether you are able to use the four areas of mental functioning age-appropriately. The fact that you have done, or currently do, some routine activities without help or support does not necessarily mean that you do not have a mental disorder or that you are not disabled. For example, you may be able to take age-appropriate care of your personal needs, or you may be old enough and able to cook, shop, and take public transportation. You may demonstrate both strengths and deficits in

your daily functioning.

b. You may receive various kinds of help and support from others that enable you to do many things that, because of your mental disorder, you might not be able to do independently. Your daily functioning may depend on the special contexts in which you function. For example, you may spend your time among only familiar people or surroundings, in a simple and steady routine or an unchanging environment, or in a highly structured classroom or alternative school. However, this does not necessarily show whether you would function age-appropriately without those supports or contexts. (See 112.00H for further discussion of these issues regarding significant deficits in adaptive functioning for the purpose of 112.05.)

4. How we consider treatment. We will consider the effect of any treatment on your functioning when we evaluate your mental disorder. Treatment may include medication(s), psychotherapy, or other forms of intervention, which you receive in a doctor's office, during a hospitalization, or in a day program at a hospital or outpatient treatment program. With treatment, you may not only have your symptoms and signs reduced, but may also be able to function age-appropriately. However, treatment may not resolve all of the limitations that result from your mental disorder, and the medications you take or other treatment you receive for your disorder may cause side effects that limit your mental or physical functioning. For example, you may experience drowsiness, blunted affect, memory loss, or abnormal involuntary movements.

E. What are the paragraph B criteria for children age 3 to the attainment of age 18?

1. Understand, remember, or apply information (paragraph B1). This area of mental functioning refers to the abilities to learn, recall, and use information to perform age-appropriate activities. Examples include: understanding and learning terms, instructions, procedures; following one- or two-step oral instructions to carry out a task; describing an activity to someone else; asking and answering questions and providing explanations; recognizing a mistake and correcting it; identifying and solving problems; sequencing multi-step activities; and using reason and judgment to make decisions. These examples illustrate the nature of the area of mental functioning. We do not require documentation of all of the examples. How you manifest this area of mental functioning and your limitations in using it depends, in part, on your age.

2. Interact with others (paragraph B2). This area of mental functioning refers to the abilities to relate to others age-appropriately at home, at school, and in the community. Examples include: engaging in interactive play; cooperating with others; asking for help when needed; initiating and maintaining friendships; handling conflicts with others; stating own point of view; initiating or sustaining conversation; understanding and responding to social cues (physical, verbal, emotional); responding to requests, suggestions, criticism, correction, and challenges; and keeping social interactions free of excessive irritability, sensitivity, argumentativeness, or suspiciousness. These examples illustrate the nature of this area of mental functioning.

We do not require documentation of all of the examples. How you manifest this area of mental functioning and your limitations in using it depends, in part, on your age.

3. Concentrate, persist, or maintain pace (paragraph B3). This area of mental functioning refers to the abilities to focus attention on activities and stay on task age-appropriately. Examples include: initiating and performing an activity that you understand and know how to do; engaging in an activity at home or in school at an appropriate and consistent pace; completing tasks in a timely manner; ignoring or avoiding distractions while engaged in an activity or task; changing activities without being disruptive; engaging in an activity or task close to or with others without interrupting or distracting them; sustaining an ordinary routine and regular attendance at school; and engaging in activities at home, school, or in the community without needing an unusual amount of rest. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples. How you manifest this area of mental functioning and your limitations in using it depends, in part, on your age.

4. Adapt or manage oneself (paragraph B4). This area of mental functioning refers to the abilities to regulate emotions, control behavior, and maintain well-being in age-appropriate activities and settings. Examples include: responding to demands; adapting to changes; managing your psychologically based symptoms; distinguishing between acceptable and unacceptable performance in community- or school-related activities; setting goals; making plans independently of others; maintaining personal

hygiene; and protecting yourself from harm and exploitation by others. These examples illustrate the nature of this area of mental functioning. We do not require documentation of all of the examples. How you manifest this area of mental functioning and your limitations in using it depends, in part, on your age.

F. How do we use the paragraph B criteria to evaluate mental disorders in children?

1. General. We use the paragraph B criteria to rate the degree of your limitations. We consider only the limitations that result from your mental disorder(s). We will determine whether you are able to use each of the paragraph B areas of mental functioning in age-appropriate activities in a manner comparable to that of other children your age who do not have impairments. We will consider, for example, the range of your activities and whether they are age-appropriate; how well you can initiate, sustain, and complete your activities; the kinds and frequency of help or supervision you receive; and the kinds of structured or supportive settings you need in order to function age-appropriately (see 112.00D).

2. Degrees of limitation. We evaluate the effects of your mental disorder on each of the four areas of mental functioning. To satisfy the paragraph B criteria, your mental disorder must result in extreme limitation of one, or marked limitation of two, paragraph B areas of mental functioning. See §§ 416.925(b)(2)(ii) and 416.926a(e) of this chapter for the definitions of the terms marked and extreme as they apply to children.

3. Rating the limitations of your areas of mental functioning.

a. General. We use all of the relevant medical and non-medical evidence in your case record to evaluate your mental disorder: the symptoms and signs of your disorder, the reported limitations in your activities, and any help and support you receive that is necessary for you to function. The medical evidence may include descriptors regarding the diagnostic stage or level of your disorder, such as “mild” or “moderate.” Clinicians may use these terms to characterize your medical condition. However, these terms will not always be the same as the degree of your limitation in a paragraph B area of mental functioning.

b. Areas of mental functioning in daily activities. You use the same four areas of mental functioning in daily activities at home, at school, and in the community. With respect to a particular task or activity, you may have trouble using one or more of the areas. For example, you may have difficulty understanding and remembering what to do; or concentrating and staying on task long enough to do it; or engaging in the task or activity with other people; or trying to do the task without becoming frustrated and losing self-control. Information about your daily functioning in your activities at home, at school, or in your community can help us understand whether your mental disorder limits one or more of these areas; and, if so, whether it also affects your ability to function age-appropriately.

c. Overall effect of limitations. Limitation of an area of mental functioning reflects the overall degree to which your mental disorder interferes with that area. The degree of limitation does not necessarily reflect a specific type or number of activities, including activities of daily living, that you have difficulty doing. In addition, no single piece of information (including test results) can establish whether you have extreme or marked limitation of an area of mental functioning.

d. Effects of support, supervision, structure on functioning. The degree of limitation of an area of mental functioning also reflects the kind and extent of supports or supervision you receive (beyond what other children your age without impairments typically receive) and the characteristics of any structured setting where you spend your time, which enable you to function. The more extensive the support you need from others (beyond what is age-appropriate) or the more structured the setting you need in order to function, the more limited we will find you to be (see 112.00D).

e. Specific instructions for paragraphs B1, B3, and B4. For paragraphs B1, B3, and B4, the greatest degree of limitation of any part of the area of mental functioning directs the rating of limitation of that whole area of mental functioning.

(i) To do an age-appropriate activity, you must be able to understand and remember and apply information required by the activity. Similarly, you must be able to concentrate and persist and maintain pace in order to complete the activity, and adapt and manage yourself age-appropriately. Limitation in any one of these parts (understand or

remember or apply; concentrate or persist or maintain pace; adapt or manage oneself) may prevent you from completing age-appropriate activities.

(ii) We will document the rating of limitation of the whole area of mental functioning, not each individual part. We will not add ratings of the parts together. For example, with respect to paragraph B3, if you have marked limitation in concentrating, but your limitations in persisting and maintaining pace do not rise to a marked level, we will find that you have marked limitation in the whole paragraph B3 area of mental functioning.

(iii) Marked limitation in more than one part of the same paragraph B area of mental functioning does not satisfy the requirement to have marked limitation in two paragraph B areas of mental functioning.

4. How we evaluate mental disorders involving exacerbations and remissions.

a. When we evaluate the effects of your mental disorder, we will consider how often you have exacerbations and remissions, how long they last, what causes your mental disorder to worsen or improve, and any other relevant information. We will assess whether your mental impairment(s) causes marked or extreme limitation of the affected paragraph B area(s) of mental functioning (see 112.00F2). We will consider whether you can use the area of mental functioning age-appropriately on a sustained basis. We will not find that you function age-appropriately solely because you have a

period(s) of improvement (remission), or that you are disabled solely because you have a period of worsening (exacerbation), of your mental disorder.

b. If you have a mental disorder involving exacerbations and remissions, you may be able to use the four areas of mental functioning at home, at school, or in the community for a few weeks or months. Recurrence or worsening of symptoms and signs, however, can interfere enough to render you unable to function age-appropriately.

G. What are the paragraph C criteria, and how do we use them to evaluate mental disorders in children age 3 to the attainment of age 18?

1. General. The paragraph C criteria are an alternative to the paragraph B criteria under listings 112.02, 112.03, 112.04, 112.06, and 112.15. We use the paragraph C criteria to evaluate mental disorders that are “serious and persistent.” In the paragraph C criteria, we recognize that mental health interventions may control the more obvious symptoms and signs of your mental disorder.

2. Paragraph C criteria.

a. We find a mental disorder to be “serious and persistent” when there is a medically documented history of the existence of the mental disorder in the listing category over a period of at least 2 years, and evidence shows that your disorder satisfies both C1 and C2.

b. The criterion in C1 is satisfied when the evidence shows that you rely, on an ongoing basis, upon medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s), to diminish the symptoms and signs of your mental disorder (see 112.00D). We consider that you receive ongoing medical treatment when the medical evidence establishes that you obtain medical treatment with a frequency consistent with accepted medical practice for the type of treatment or evaluation required for your medical condition. We will consider periods of inconsistent treatment or lack of compliance with treatment that may result from your mental disorder. If the evidence indicates that the inconsistent treatment or lack of compliance is a feature of your mental disorder, and it has led to an exacerbation of your symptoms and signs, we will not use it as evidence to support a finding that you have not received ongoing medical treatment as required by this paragraph.

c. The criterion in C2 is satisfied when the evidence shows that, despite your diminished symptoms and signs, you have achieved only marginal adjustment. “Marginal adjustment” means that your adaptation to the requirements of daily life is fragile; that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life. We will consider that you have achieved only marginal adjustment when the evidence shows that changes or increased demands have led to exacerbation of your symptoms and signs and to deterioration in your functioning; for example, you have become unable to function outside of your home or a more restrictive setting, without substantial psychosocial supports (see 112.00D).

Such deterioration may have necessitated a significant change in medication or other treatment. Similarly, because of the nature of your mental disorder, evidence may document episodes of deterioration that have required you to be hospitalized or absent from school, making it difficult for you to sustain age-appropriate activity over time.

H. How do we document and evaluate intellectual disorder under 112.05?

1. General. Listing 112.05 is based on the two elements that characterize intellectual disorder for children up to age 18: significantly subaverage general intellectual functioning and significant deficits in current adaptive functioning.

2. Establishing significantly subaverage general intellectual functioning.

a. Definition. Intellectual functioning refers to the general mental capacity to learn, reason, plan, solve problems, and perform other cognitive functions. Under 112.05A, we identify significantly subaverage general intellectual functioning by the cognitive inability to function at a level required to participate in standardized intelligence testing. Our findings under 112.05A are based on evidence from an acceptable medical source. Under 112.05B, we identify significantly subaverage general intellectual functioning by an IQ score(s) on an individually administered standardized test of general intelligence that meets program requirements and has a mean of 100 and a standard deviation of 15. A qualified specialist (see 112.00H2c) must administer the standardized intelligence testing.

b. Psychometric standards. We will find standardized intelligence test results usable for the purposes of 112.05B1 when the measure employed meets contemporary psychometric standards for validity, reliability, normative data, and scope of measurement; and a qualified specialist has individually administered the test according to all pre-requisite testing conditions.

c. Qualified specialist. A “qualified specialist” is currently licensed or certified at the independent level of practice in the State where the test was performed, and has the training and experience to administer, score, and interpret intelligence tests. If a psychological assistant or paraprofessional administered the test, a supervisory qualified specialist must interpret the test findings and co-sign the examination report.

d. Responsibility for conclusions based on testing. We generally presume that your obtained IQ score(s) is an accurate reflection of your general intellectual functioning, unless evidence in the record suggests otherwise. Examples of this evidence include: a statement from the test administrator indicating that your obtained score is not an accurate reflection of your general intellectual functioning, prior or internally inconsistent IQ scores, or information about your daily functioning. Only qualified specialists, Federal and State agency medical and psychological consultants, and other contracted medical and psychological experts may conclude that your obtained IQ score(s) is not an accurate reflection of your general intellectual functioning. This conclusion must be well supported by appropriate clinical and laboratory diagnostic

techniques and must be based on relevant evidence in the case record, such as:

(i) The data obtained in testing;

(ii) Your developmental history, including when your signs and symptoms began;

(iii) Information about how you function on a daily basis in a variety of settings;

and

(iv) Clinical observations made during the testing period, such as your ability to sustain attention, concentration, and effort; to relate appropriately to the examiner; and to perform tasks independently without prompts or reminders.

3. Establishing significant deficits in adaptive functioning.

a. Definition. Adaptive functioning refers to how you learn and use conceptual, social, and practical skills in dealing with common life demands. It is your typical functioning at home, at school, and in the community, alone or among others. Under 112.05A, we identify significant deficits in adaptive functioning based on your dependence on others to care for your personal needs, such as eating and bathing (grossly in excess of age-appropriate dependence). We will base our conclusions about your adaptive functioning on evidence from a variety of sources (see 112.00H3b) and not on your statements alone. Under 112.05B2, we identify significant deficits in adaptive

functioning based on whether there is extreme limitation of one, or marked limitation of two, of the paragraph B criteria (see 112.00E; 112.00F).

b. Evidence. Evidence about your adaptive functioning may come from:

(i) Medical sources, including their clinical observations;

(ii) Standardized tests of adaptive functioning (see 112.00H3c);

(iii) Third party information, such as a report of your functioning from a family member or your caregiver;

(iv) School records;

(v) A teacher questionnaire;

(vi) Reports from employers or supervisors; and

(vii) Your own statements about how you handle all of your daily activities.

c. Standardized tests of adaptive functioning. We do not require the results of an individually administered standardized test of adaptive functioning. If your case record includes these test results, we will consider the results along with all other relevant

evidence; however, we will use the guidelines in 112.00E and F to evaluate and determine the degree of your deficits in adaptive functioning, as required under 112.05B2.

d. Standardized developmental assessments. We do not require the results of standardized developmental assessments, which compare your level of development to the level typically expected for your chronological age. If your case record includes test results, we will consider the results along with all other relevant evidence. However, we will use the guidelines in 112.00E and F to evaluate and determine the degree of your deficits in adaptive functioning, as required under 112.05B2.

e. How we consider common everyday activities.

(i) The fact that you engage in common everyday activities, such as caring for your personal needs, preparing simple meals, or driving a car, will not always mean that you do not have deficits in adaptive functioning as required by 112.05B2. You may demonstrate both strengths and deficits in your adaptive functioning. However, a lack of deficits in one area does not negate the presence of deficits in another area. When we assess your adaptive functioning, we will consider all of your activities and your performance of them.

(ii) Our conclusions about your adaptive functioning rest on the quality of your daily activities and whether you do them age-appropriately. If you receive help in

performing your activities, we need to know the kind, extent, and frequency of help you receive in order to perform them. We will not assume that your ability to do some common everyday activities, or to do some things without help or support, demonstrates that your mental disorder does not meet the requirements of 112.05B2. (See 112.00D regarding the factors we consider when we evaluate your functioning, including how we consider any help or support you receive.)

f. How we consider work activity. The fact that you have engaged in work activity, or that you work intermittently or steadily in a job commensurate with your abilities, will not always mean that you do not have deficits in adaptive functioning as required by 112.05B2. When you have engaged in work activity, we need complete information about the work, and about your functioning in the work activity and work setting, before we reach any conclusions about your adaptive functioning. We will consider all factors involved in your work history before concluding whether your impairment satisfies the criteria for intellectual disorder under 112.05B. We will consider your prior and current work history, if any, and various other factors influencing how you function. For example, we consider whether the work was in a supported setting, whether you required more supervision than other employees, how your job duties compared to others in the same job, how much time it took you to learn the job duties, and the reason the work ended, if applicable.

I. What additional considerations do we use to evaluate developmental disorders of infants and toddlers?

1. General. We evaluate developmental disorders from birth to attainment of age 3 under 112.14. We evaluate your ability to acquire and maintain the motor, cognitive, social/communicative, and emotional skills that you need to function age-appropriately. When we rate your impairment-related limitations for this listing (see §§ 416.925(b)(2)(ii) and 416.926a(e) of this chapter), we consider only limitations you have because of your developmental disorder. If you have a chronic illness or physical abnormality(ies), we will evaluate it under the affected body system, for example, the cardiovascular or musculoskeletal system.

2. Age and typical development in early childhood.

a. Prematurity and age. If you were born prematurely, we will use your corrected chronological age (CCA) for comparison. CCA is your chronological age adjusted by a period of gestational prematurity. $CCA = (\text{chronological age}) - (\text{number of weeks premature})$. If you have not attained age 1, we will correct your chronological age, using the same formula. If you are over age 1, we will decide whether to correct your chronological age, based on our judgment and all the facts of your case (see § 416.924b(b) of this chapter).

b. Developmental assessment. We will use the results from a standardized developmental assessment to compare your level of development with that typically expected for your chronological age. When there are no results from a comprehensive

standardized developmental assessment in the case record, we need narrative developmental reports from your medical sources in sufficient detail to assess the limitations resulting from your developmental disorder.

c. Variation. When we evaluate your developmental disorder, we will consider the wide variation in the range of normal or typical development in early childhood. At the end of a recognized milestone period, new skills typically begin to emerge. If your new skills begin to emerge later than is typically expected, the timing of their emergence may or may not indicate that you have a developmental delay or deficit that can be expected to last for 1 year.

3. Evidence.

a. Standardized developmental assessments. We use standardized test reports from acceptable medical sources or from early intervention specialists, physical or occupational therapists, and other qualified professionals. Only the qualified professional who administers the test, Federal and State agency medical and psychological consultants, and other contracted medical and psychological experts may conclude that the assessment results are not an accurate reflection of your development. This conclusion must be well supported by appropriate clinical and laboratory diagnostic techniques and must be based on relevant evidence in the case record. If the assessment results are not an accurate reflection of your development, we may purchase a new developmental assessment. If the developmental assessment is inconsistent with other

information in your case record, we will follow the guidelines in § 416.920b of this chapter.

b. Narrative developmental reports. A narrative developmental report is based on clinical observations, progress notes, and well-baby check-ups, and includes your developmental history, examination findings (with abnormal findings noted on repeated examinations), and an overall assessment of your development (that is, more than one or two isolated skills) by the medical source. Although medical sources may refer to screening test results as supporting evidence in the narrative developmental report, screening test results alone cannot establish a diagnosis or the severity of developmental disorder.

4. What are the paragraph B criteria for 112.14?

a. General. The paragraph B criteria for 112.14 are slightly different from the paragraph B criteria for the other listings. They are the developmental abilities that infants and toddlers use to acquire and maintain the skills needed to function age-appropriately. An infant or toddler is expected to use his or her developmental abilities to achieve a recognized pattern of milestones, over a typical range of time, in order to acquire and maintain the skills needed to function age-appropriately. We will find that your developmental disorder satisfies the requirements of 112.14 if it results in extreme limitation of one, or marked limitation of two, of the 112.14 paragraph B criteria. (See §§ 416.925(b)(2)(ii) and 416.926a(e) of this chapter for the definitions of the terms

marked and extreme as they apply to children.)

b. Definitions of the 112.14 paragraph B developmental abilities.

(i) Ability to plan and control motor movement. This criterion refers to the developmental ability to plan, remember, and execute controlled motor movements by integrating and coordinating perceptual and sensory input with motor output. Using this ability develops gross and fine motor skills, and makes it possible for you to engage in age-appropriate symmetrical or alternating motor activities. You use this ability when, for example, you grasp and hold objects with one or both hands, pull yourself up to stand, walk without holding on, and go up and down stairs with alternating feet. These examples illustrate the nature of the developmental ability. We do not require documentation of all of the examples. How you manifest this developmental ability and your limitations in using it depends, in part, on your age.

(ii) Ability to learn and remember. This criterion refers to the developmental ability to learn by exploring the environment, engaging in trial-and-error experimentation, putting things in groups, understanding that words represent things, and participating in pretend play. Using this ability develops the skills that help you understand what things mean, how things work, and how you can make things happen. You use this ability when, for example, you show interest in objects that are new to you, imitate simple actions, name body parts, understand simple cause-and-effect relationships, remember simple directions, or figure out how to take something apart.

These examples illustrate the nature of the developmental ability. We do not require documentation of all of the examples. How you manifest this developmental ability and your limitations in using it depends, in part, on your age.

(iii) Ability to interact with others. This criterion refers to the developmental ability to participate in reciprocal social interactions and relationships by communicating your feelings and intents through vocal and visual signals and exchanges; physical gestures and contact; shared attention and affection; verbal turn taking; and understanding and sending increasingly complex messages. Using this ability develops the social skills that make it possible for you to influence others (for example, by gesturing for a toy or saying “no” to stop an action); invite someone to interact with you (for example, by smiling or reaching); and draw someone’s attention to what interests you (for example, by pointing or taking your caregiver’s hand and leading that person). You use this ability when, for example, you use vocalizations to initiate and sustain a “conversation” with your caregiver; respond to limits set by an adult with words, gestures, or facial expressions; play alongside another child; or participate in simple group activities with adult help. These examples illustrate the nature of the developmental ability. We do not require documentation of all of the examples. How you manifest this developmental ability and your limitations in using it depends, in part, on your age.

(iv) Ability to regulate physiological functions, attention, emotion, and behavior. This criterion refers to the developmental ability to stabilize biological rhythms (for

example, by developing an age-appropriate sleep/wake cycle); control physiological functions (for example, by achieving regular patterns of feeding); and attend, react, and adapt to environmental stimuli, persons, objects, and events (for example, by becoming alert to things happening around you and in relation to you, and responding without overreacting or underreacting). Using this ability develops the skills you need to regulate yourself and makes it possible for you to achieve and maintain a calm, alert, and organized physical and emotional state. You use this ability when, for example, you recognize your body's needs for food or sleep, focus quickly and pay attention to things that interest you, cry when you are hurt but become quiet when your caregiver holds you, comfort yourself with your favorite toy when you are upset, ask for help when something frustrates you, or refuse help from your caregiver when trying to do something for yourself. These examples illustrate the nature of the developmental ability. We do not require documentation of all of the examples. How you manifest this developmental ability and your limitations in using it depends, in part, on your age.

5. Deferral of determination.

a. Full-term infants. In the first few months of life, full-term infants typically display some irregularities in observable behaviors (for example, sleep cycles, feeding, responding to stimuli, attending to faces, self-calming), making it difficult to assess the presence, extent, and duration of a developmental disorder. When the evidence indicates that you may have a significant developmental delay, but there is insufficient evidence to make a determination, we will defer making a disability determination under 112.14 until

you are at least 6 months old. This deferral will allow us to obtain a longitudinal medical history so that we can more accurately evaluate your developmental patterns and functioning over time. In most cases, when you are at least 6 months old, any developmental delay you may have can be better assessed, and you can undergo standardized developmental testing, if indicated.

b. Premature infants. When the evidence indicates that you may have a significant developmental delay, but there is insufficient evidence to make a determination, we will defer your case until you attain a CCA (see 112.00I2a) of at least 6 months in order to better evaluate your developmental delay.

c. When we will not defer a determination. We will not defer our determination if we have sufficient evidence to determine that you are disabled under 112.14 or any other listing, or that you have an impairment or combination of impairments that functionally equals the listings. In addition, we will not defer our determination if the evidence demonstrates that you are not disabled.

J. How do we evaluate substance use disorders? If we find that you are disabled and there is medical evidence in your case record establishing that you have a substance use disorder, we will determine whether your substance use disorder is a contributing factor material to the determination of disability (see § 416.935 of this chapter).

K. How do we evaluate mental disorders that do not meet one of the mental

disorders listings?

1. These listings include only examples of mental disorders that we consider serious enough to result in marked and severe functional limitations. If your severe mental disorder does not meet the criteria of any of these listings, we will consider whether you have an impairment(s) that meets the criteria of a listing in another body system. You may have another impairment(s) that is secondary to your mental disorder. For example, if you have an eating disorder and develop a cardiovascular impairment because of it, we will evaluate your cardiovascular impairment under the listings for the cardiovascular body system.

2. If you have a severe medically determinable impairment(s) that does not meet a listing, we will determine whether your impairment(s) medically equals a listing (see § 416.926 of this chapter).

3. If your impairment(s) does not meet or medically equal a listing, we will consider whether you have an impairment(s) that functionally equals the listings (see § 416.926a of this chapter).

4. Although we present these alternatives in a specific sequence above, each represents listing-level severity, and we can evaluate your claim in any order. For example, if the factors of your case indicate that the combination of your impairments may functionally equal the listings, we may start with that analysis. We use the rules in §

416.994a of this chapter, as appropriate, when we decide whether you continue to be disabled.

112.01 Category of Impairments, Mental Disorders

112.02 Neurocognitive disorders (see 112.00B1), for children age 3 to attainment of age 18, satisfied by A and B, or A and C:

A. Medical documentation of a clinically significant deviation in normal cognitive development or by significant cognitive decline from a prior level of functioning in one or more of the cognitive areas:

1. Complex attention;
2. Executive function;
3. Learning and memory;
4. Language;
5. Perceptual-motor; or
6. Social cognition.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):

1. Understand, remember, or apply information (see 112.00E1).
2. Interact with others (see 112.00E2).
3. Concentrate, persist, or maintain pace (see 112.00E3).
4. Adapt or manage oneself (see 112.00E4).

OR

C. Your mental disorder in this listing category is “serious and persistent,” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 112.00G2b); and

2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 112.00G2c).

112.03 Schizophrenia spectrum and other psychotic disorders (see 112.00B2), for children age 3 to attainment of age 18, satisfied by A and B, or A and C:

A. Medical documentation of one or more of the following:

1. Delusions or hallucinations;
2. Disorganized thinking (speech); or
3. Grossly disorganized behavior or catatonia.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):

1. Understand, remember, or apply information (see 112.00E1).

2. Interact with others (see 112.00E2).

3. Concentrate, persist, or maintain pace (see 112.00E3).

4. Adapt or manage oneself (see 112.00E4).

OR

C. Your mental disorder in this listing category is “serious and persistent;” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 112.00G2b); and

2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 112.00G2c).

112.04 Depressive, bipolar and related disorders (see 112.00B3), for children age 3 to attainment of age 18, satisfied by A and B, or A and C:

A. Medical documentation of the requirements of paragraph 1, 2, or 3:

1. Depressive disorder, characterized by five or more of the following:

a. Depressed or irritable mood;

b. Diminished interest in almost all activities;

c. Appetite disturbance with change in weight (or a failure to achieve an expected weight gain);

d. Sleep disturbance;

e. Observable psychomotor agitation or retardation;

f. Decreased energy;

g. Feelings of guilt or worthlessness;

h. Difficulty concentrating or thinking; or

i. Thoughts of death or suicide.

2. Bipolar disorder, characterized by three or more of the following:

a. Pressured speech;

b. Flight of ideas;

c. Inflated self-esteem;

d. Decreased need for sleep;

e. Distractibility;

f. Involvement in activities that have a high probability of painful consequences that are not recognized; or

g. Increase in goal-directed activity or psychomotor agitation.

3. Disruptive mood dysregulation disorder, beginning prior to age 10, and all of the following:

a. Persistent, significant irritability or anger;

b. Frequent, developmentally inconsistent temper outbursts; and

c. Frequent aggressive or destructive behavior.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):

1. Understand, remember, or apply information (see 112.00E1).

2. Interact with others (see 112.00E2).

3. Concentrate, persist, or maintain pace (see 112.00E3).

4. Adapt or manage oneself (see 112.00E4).

OR

C. Your mental disorder in this listing category is “serious and persistent;” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly

structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 112.00G2b); and

2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 112.00G2c).

112.05 Intellectual disorder (see 112.00B4), for children age 3 to attainment of age 18, satisfied by A or B:

A. Satisfied by 1 and 2 (see 112.00H):

1. Significantly subaverage general intellectual functioning evident in your cognitive inability to function at a level required to participate in standardized testing of intellectual functioning; and

2. Significant deficits in adaptive functioning currently manifested by your dependence upon others for personal needs (for example, toileting, eating, dressing, or bathing) in excess of age-appropriate dependence.

OR

B. Satisfied by 1 and 2 (see 112.00H):

1. Significantly subaverage general intellectual functioning evidenced by a or b:
 - a. A full scale (or comparable) IQ score of 70 or below on an individually administered standardized test of general intelligence; or
 - b. A full scale (or comparable) IQ score of 71-75 accompanied by a verbal or performance IQ score (or comparable part score) of 70 or below on an individually administered standardized test of general intelligence; and
2. Significant deficits in adaptive functioning currently manifested by extreme limitation of one, or marked limitation of two, of the following areas of mental functioning:
 - a. Understand, remember, or apply information (see 112.00E1); or
 - b. Interact with others (see 112.00E2); or
 - c. Concentrate, persist, or maintain pace (see 112.00E3); or
 - d. Adapt or manage oneself (see 112.00E4).

112.06 Anxiety and obsessive-compulsive disorders (see 112.00B5), for children

age 3 to attainment of age 18, satisfied by A and B, or A and C:

A. Medical documentation of the requirements of paragraph 1, 2, 3, or 4:

1. Anxiety disorder, characterized by one or more of the following:

a. Restlessness;

b. Easily fatigued;

c. Difficulty concentrating;

d. Irritability;

e. Muscle tension; or

f. Sleep disturbance.

2. Panic disorder or agoraphobia, characterized by one or both:

a. Panic attacks followed by a persistent concern or worry about additional panic attacks or their consequences; or

b. Disproportionate fear or anxiety about at least two different situations (for example, using public transportation, being in a crowd, being in a line, being outside of your home, being in open spaces).

3. Obsessive-compulsive disorder, characterized by one or both:

a. Involuntary, time-consuming preoccupation with intrusive, unwanted thoughts;
or;

b. Repetitive behaviors that appear aimed at reducing anxiety.

4. Excessive fear or anxiety concerning separation from those to whom you are attached.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):

1. Understand, remember, or apply information (see 112.00E1).

2. Interact with others (see 112.00E2).

3. Concentrate, persist, or maintain pace (see 112.00E3).

4. Adapt or manage oneself (see 112.00E4).

OR

C. Your mental disorder in this listing category is “serious and persistent,” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 112.00G2b); and

2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 112.00G2c).

112.07 Somatic symptom and related disorders (see 112.00B6), for children age 3 to attainment of age 18, satisfied by A and B:

A. Medical documentation of one or both of the following:

1. Symptoms of altered voluntary motor or sensory function that are not better explained by another medical or mental disorder; or

2. One or more somatic symptoms that are distressing, with excessive thoughts, feelings, or behaviors related to the symptoms.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):

1. Understand, remember, or apply information (see 112.00E1).

2. Interact with others (see 112.00E2).

3. Concentrate, persist, or maintain pace (see 112.00E3).

4. Adapt or manage oneself (see 112.00E4).

112.08 Personality and impulse-control disorders (see 112.00B7), for children age 3 to attainment of age 18, satisfied by A and B:

A. Medical documentation of a pervasive pattern of one or more of the following:

1. Distrust and suspiciousness of others;
2. Detachment from social relationships;
3. Disregard for and violation of the rights of others;
4. Instability of interpersonal relationships;
5. Excessive emotionality and attention seeking;
6. Feelings of inadequacy;
7. Excessive need to be taken care of;
8. Preoccupation with perfectionism and orderliness; or
9. Recurrent, impulsive, aggressive behavioral outbursts.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas

of mental functioning (see 112.00F):

1. Understand, remember, or apply information (see 112.00E1).
2. Interact with others (see 112.00E2).
3. Concentrate, persist, or maintain pace (see 112.00E3).
4. Adapt or manage oneself (see 112.00E4).

112.09 [Reserved]

112.10 Autism spectrum disorder (see 112.00B8), for children age 3 to attainment of age 18), satisfied by A and B:

A. Medical documentation of both of the following:

1. Qualitative deficits in verbal communication, nonverbal communication, and social interaction; and
2. Significantly restricted, repetitive patterns of behavior, interests, or activities.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):

1. Understand, remember, or apply information (see 112.00E1).
2. Interact with others (see 112.00E2).
3. Concentrate, persist, or maintain pace (see 112.00E3).
4. Adapt or manage oneself (see 112.00E4).

112.11 Neurodevelopmental disorders (see 112.00B9), for children age 3 to attainment of age 18, satisfied by A and B:

A. Medical documentation of the requirements of paragraph 1, 2, or 3:

1. One or both of the following:

a. Frequent distractibility, difficulty sustaining attention, and difficulty organizing tasks; or

b. Hyperactive and impulsive behavior (for example, difficulty remaining seated,

talking excessively, difficulty waiting, appearing restless, or behaving as if being “driven by a motor”).

2. Significant difficulties learning and using academic skills; or

3. Recurrent motor movement or vocalization.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):

1. Understand, remember, or apply information (see 112.00E1).

2. Interact with others (see 112.00E2).

3. Concentrate, persist, or maintain pace (see 112.00E3).

4. Adapt or manage oneself (see 112.00E4).

112.12 [Reserved]

112.13 Eating disorders (see 112.00B10), for children age 3 to attainment of age

18, satisfied by A and B:

A. Medical documentation of a persistent alteration in eating or eating-related behavior that results in a change in consumption or absorption of food and that significantly impairs physical or psychological health.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):

1. Understand, remember, or apply information (see 112.00E1).

2. Interact with others (see 112.00E2).

3. Concentrate, persist, or maintain pace (see 112.00E3).

4. Adapt or manage oneself (see 112.00E4).

112.14 Developmental disorders in infants and toddlers (see 112.00B11, 112.00I),
satisfied by A and B:

A. Medical documentation of one or both of the following:

1. A delay or deficit in the development of age-appropriate skills; or
2. A loss of previously acquired skills.

AND

B. Extreme limitation of one, or marked limitation of two, of the following developmental abilities (see 112.00F):

1. Plan and control motor movement (see 112.00I4b(i)).
2. Learn and remember (see 112.00I4b(ii)).
3. Interact with others (see 112.00I4b(iii)).
4. Regulate physiological functions, attention, emotion, and behavior (see 112.00I4b(iv)).

112.15 Trauma- and stressor-related disorders (see 112.00B11), for children age 3 to attainment of age 18, satisfied by A and B, or A and C:

- A. Medical documentation of the requirements of paragraph 1 or 2:

1. Posttraumatic stress disorder, characterized by all of the following:
 - a. Exposure to actual or threatened death, serious injury, or violence;
 - b. Subsequent involuntary re-experiencing of the traumatic event (for example, intrusive memories, dreams, or flashbacks);
 - c. Avoidance of external reminders of the event;
 - d. Disturbance in mood and behavior (for example, developmental regression, socially withdrawn behavior); and
 - e. Increases in arousal and reactivity (for example, exaggerated startle response, sleep disturbance).
2. Reactive attachment disorder, characterized by two or all of the following:
 - a. Rarely seeks comfort when distressed;
 - b. Rarely responds to comfort when distressed; or
 - c. Episodes of unexplained emotional distress.

AND

B. Extreme limitation of one, or marked limitation of two, of the following areas of mental functioning (see 112.00F):

1. Understand, remember, or apply information (see 112.00E1).
2. Interact with others (see 112.00E2).
3. Concentrate, persist, or maintain pace (see 112.00E3).
4. Adapt or manage oneself (see 112.00E4).

OR

C. Your mental disorder in this listing category is “serious and persistent;” that is, you have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both:

1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 112.00G2b); and

2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 112.00G2c).

* * * * *

114.00 Immune System Disorders

* * * * *

D. * * *

6. * * *

e. * * *

(ii) Listing-level severity is shown in 114.09B and 114.09C2 by inflammatory arthritis that involves various combinations of complications of one or more major peripheral joints or involves other joints, such as inflammation or deformity, extra-articular features, repeated manifestations, and constitutional symptoms and signs. * * *

* * * * *

114.02 Systemic lupus erythematosus, as described in 114.00D1. With involvement of two or more organs/body systems, and with:

A. One of the organs/body systems involved to at least a moderate level of severity;

AND

B. At least two of the constitutional symptoms and signs (severe fatigue, fever, malaise, or involuntary weight loss).

114.03 Systemic vasculitis, as described in 114.00D2. With involvement of two or more organs/body systems, and with:

A. One of the organs/body systems involved to at least a moderate level of severity;

AND

B. At least two of the constitutional symptoms and signs (severe fatigue, fever, malaise, or involuntary weight loss).

* * * * *

114.06 Undifferentiated and mixed connective tissue disease, as described in
114.00D5. With involvement of two or more organs/body systems, and with:

A. One of the organs/body systems involved to at least a moderate level of
severity;

AND

B. At least two of the constitutional symptoms and signs (severe fatigue, fever,
malaise, or involuntary weight loss).

* * * * *

114.10 Sjögren's syndrome, as described in 114.00D7. With involvement of two
or more organs/body systems, and with:

A. One of the organs/body systems involved to at least a moderate level of
severity;

AND

B. At least two of the constitutional symptoms and signs (severe fatigue, fever, malaise, or involuntary weight loss).

* * * * *

PART 416—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND,
AND DISABLED

Subpart I—Determining Disability and Blindness

4. The authority citation for subpart I of part 416 continues to read as follows:

Authority: Secs. 221(m), 702(a)(5), 1611, 1614, 1619, 1631(a), (c), (d)(1), and (p), and 1633 of the Social Security Act (42 U.S.C. 421(m), 902(a)(5), 1382, 1382c, 1382h, 1383(a), (c), (d)(1), and (p), and 1383b); secs. 4(c) and 5, 6(c)-(e), 14(a), and 15, Pub. L. 98-460, 98 Stat. 1794, 1801, 1802, and 1808 (42 U.S.C. 421 note, 423 note, and 1382h note).

5. Amend § 416.920a by revising paragraphs (c)(3) and (4) and (d)(1) to read as follows:

§ 416.920a Evaluation of mental impairments.

* * * * *

(c) * * *

(3) We have identified four broad functional areas in which we will rate the degree of your functional limitation: understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself. See 12.00E of the Listing of Impairments in appendix 1 to subpart P of part 404 of this chapter.

(4) When we rate your degree of limitation in these areas (understand, remember, or apply information; interact with others; concentrate, persist, or maintain pace; and adapt or manage oneself), we will use the following five-point scale: none, mild, moderate, marked, and extreme. The last point on the scale represents a degree of limitation that is incompatible with the ability to do any gainful activity.

(d) * * *

(1) If we rate the degrees of your limitation as “none” or “mild,” we will generally conclude that your impairment(s) is not severe, unless the evidence otherwise indicates that there is more than a minimal limitation in your ability to do basic work activities (see § 416.921).

* * * * *

6. Amend § 416.934 by revising the section heading and paragraph (h) to read as follows:

§ 416.934 Impairments that may warrant a finding of presumptive disability or presumptive blindness.

* * * * *

(h) Allegation of intellectual disability or another neurodevelopmental impairment (for example, autism spectrum disorder) with complete inability to independently perform basic self-care activities (such as toileting, eating, dressing, or bathing) made by another person who files on behalf of a claimant who is at least 4 years old.

* * * * *

[FR Doc. 2016-22908 Filed: 9/23/2016 8:45 am; Publication Date: 9/26/2016]